No. 05-200

Title:	Empire HealthChoice Assurance, Inc., dba Empire Blue Cross Blue Shield, Petitioner v. Denise F. McVeigh, as Administratrix of the Estate of Joseph E. McVeigh
Docketed:	August 10, 2005
Lower Ct:	United States Court of Appeals for the Second Circuit
Case Nos.:	(03 9098)
Decision Date:	January 14, 2005
Rehearing Denied:	May 10, 2005

Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~~~
Aug 8 2005	Petition for a writ of certiorari filed. (Response due September 9, 2005)
Sep 2 2005	Brief of respondent Denise F. McVeigh, as Administratrix of the Estate of Joseph E. McVeigh in opposition filed.
Sep 14 2005	DISTRIBUTED for Conference of October 7, 2005.
Sep 21 2005	Reply of petitioner Empire HealthChoice Assurance, Inc. filed. (Distributed)
Oct 11 2005	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
Dec 9 2005	Brief amicus curiae of United States filed. VIDED.
Dec 16 2005	Reply of respondent Denise F. McVeigh to the amicus brief of the United States filed. (Distributed).
Dec 21 2005	DISTRIBUTED for Conference of January 6, 2006.
Jan 5 2006	Briefs received from U.S.C.A. 2nd Circuit. (1 envelope)
Jan 6 2006	Petition GRANTED.
Feb 15 2006	Extension of time within which to file the joint appendix and petitioner's brief on the merits to and including February 24, 2006.
Feb 24 2006	Brief amicus curiae of United States filed.
Feb 24 2006	Joint appendix filed. (Jt appendix in two volumes)
Feb 24 2006	Brief of petitioner Empire HealthChoice Assurance, Inc. filed.
Mar 6 2006	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Mar 6 2006	SET FOR ARGUMENT on Tuesday, April 25, 2006.
Mar 23 2006	CIRCULATED.
Mar 24 2006	Record received from U.S.D.C. Southern District of New York. (1 box)
Mar 28 2006	Brief of respondent Denise F. McVeigh, as Administratrix of the Estate of

	Joseph E. McVeigh filed. (Distributed)
Mar 31 2006	Brief amicus curiae of Julia Cruz, as Representative of Jose S. Cruz filed. (Distributed)
Apr 7 2006	Motion of Julia Cruz, as Representative of Jose S. Cruz for leave to participate in oral argument as amicus curiae and for divided argument filed.
Apr 14 2006	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Apr 14 2006	Motion of Julia Cruz, as Representative of Jose S. Cruz for leave to participate in oral argument as amicus curiae and for divided argument DENIED.
Apr 18 2006	Reply of petitioner Empire HealthChoice Assurance, Inc. filed. (Distributed)
Apr 25 2006	Argued. For petitioner: Anthony F. Shelley, Washington, D.C.; and Sri Srinivasan, Assistant to the Solicitor General, Department of Justice; Washington, D.C. (as amicus curiae, supporting petitioner). For respondent: Thomas J. Stock, Mineola, N.Y.
Apr 28 2006	Record received from U.S.C.A. 2nd Circuit. 1 envelope

Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,

Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether federal question jurisdiction exists over a suit by a federal government contractor to enforce, on behalf of the United States, a provision in a health benefits plan for federal employees that is part of a government contract established pursuant to the Federal Employees Health Benefits Act.

PARTIES TO THE PROCEEDING

All of the parties to the proceeding are identified in the case caption.

STATEMENT PURSUANT TO RULE 29.6

Empire HealthChoice Assurance, Inc., doing business as Empire Blue Cross Blue Shield, is wholly owned by WellChoice, Inc. through WellChoice Holdings of New York, Inc. WellChoice, Inc. is a publicly traded company, and no publicly held company owns ten percent or more of its stock. Neither Empire HealthChoice Assurance, Inc., nor WellChoice Holdings of New York, Inc., is publicly traded.

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Empire HealthChoice Assurance, Inc. ("Empire") petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-45a) is reported at 396 F.3d 136. The opinion of the court of appeals denying petitioner's petition for panel rehearing (Pet. App. 46a-51a) is reported at 402 F.3d 107. The order of the court of appeals denying petitioner's petition for panel rehearing and for rehearing en banc (Pet. App. 52a-53a) is not reported. The opinion of the district court is not reported but can be found at 2003 U.S. Dist. LEXIS 16276 (Pet. App. 54a-62a).

JURISDICTION

The judgment of the court of appeals was entered on January 14, 2005. Petitioner timely filed a petition for rehearing and for rehearing en banc. The court of appeals denied the petition for rehearing and for rehearing en banc on May 10, 2005. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914, provides in pertinent part:

5 U.S.C. § 8902(a):

The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

5 U.S.C. § 8902(d):

Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

5 U.S.C. § 8902(m)(1):

The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

STATEMENT

In this action, a divided court of appeals held that the federal courts lack subject matter jurisdiction over a suit to enforce the terms of a health benefits plan governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. The suit was commenced by Empire, which administers, in parts of New York, the largest plan in the FEHBA program: the Service Benefit Plan (or the "Plan"). Local Blue Cross and Blue Shield entities, including Empire, administer the Plan in their particular localities pursuant to a federal government contract entered on their behalf by the Blue Cross and Blue Shield Association ("BCBSA") with the United States Office of Personnel Management ("OPM"). The Service Benefit Plan provides health benefits to over 4 million federal employees and annuitants and their dependents. Overall, approximately 8.5 million individuals obtain health benefits coverage through FEHBA-governed plans.

The particular Service Benefit Plan terms involved in this controversy concern reimbursement of benefits. Reimbursement is a species of subrogation and arises when the Plan has paid benefits to an enrollee for injuries and the enrollee then also collects from a third party in connection with those same injuries. In such circumstances, the Plan's provisions mandate

that the enrollee must reimburse the Plan for the benefits it has paid.

Here, after Empire brought suit to enforce the reimbursement terms against the estate of an enrollee who refused to comply with those terms, the court of appeals rejected federal question jurisdiction. It did so notwithstanding that the money collected through reimbursement inures to the benefit of the United States, the reimbursement terms were promulgated by OPM and are part of the government contract with BCBSA, FEHBA contains a broad preemption provision displacing state law that relates to health benefits, and other courts of appeals have reached the opposite result on the same issue. The Court should grant the petition for certiorari to resolve the resulting conflict in the circuits and to correct an erroneous decision that threatens turmoil in a significant national federal program.

A. The Statutory, Regulatory, and Contractual Scheme

1. *The Service Benefit Plan*. Congress enacted FEHBA in 1959 to provide "a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive government-wide program of insurance for federal employees . . . , the costs of which [would] be shared by the Government, as employer, and its employees." H.R. Rep. No. 86-957, at 1 (1959), *reprinted in* 1959 U.S.C.C.A.N. 2913, 2914. Overall, Congress sought to "assure maximum health benefits for employees at the lowest possible costs to themselves and to the Government." *Id.* at 4, *reprinted in* 1959 U.S.C.C.A.N. at 2916.

To achieve these goals, FEHBA delegates expansive authority to OPM. The statute "'gives OPM the authority to administer the program by contracting with qualified private carriers to offer a variety of health care plans, 5 U.S.C. § 8902, distributing information on the available plans to eligible employees, [5 U.S.C.] § 8907, by promulgating necessary regulations [5 U.S.C.] § 8913, and by interpreting the plans to

determine the carrier's liability in an individual case, [5 U.S.C.] § 8902(j).'" *Muratore v. United States OPM*, 222 F.3d 918, 920 (11th Cir. 2000) (quoting *Kobleur v. Group Hosp. & Med. Servs.*, 954 F.2d 705, 709 (11th Cir. 1992)) (brackets in original).

One plan for which OPM has contracted is the Service Benefit Plan, a nationwide fee-for-service plan expressly described in FEHBA. 5 U.S.C. § 8903(1). In 1960, OPM contracted with BCBSA to provide the Service Benefit Plan. In signing the contract, BCBSA acts on behalf of the local Blue Cross and Blue Shield companies who administer the Plan in their respective localities. OPM and BCBSA annually renegotiate the government contract for the Service Benefit Plan, including the premium rates and the scope of benefits to be provided under the Plan.

2. *Plan Benefits Terms and Limitations*. By statute, each FEHBA contract, including the Service Benefit Plan, "shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." 5 U.S.C. § 8902(d). The Statement of Benefits for the Service Benefit Plan is attached to and incorporated into the OPM-BCBSA contract and is the official description of benefits and other Plan terms. Court of Appeals App. ("J.A.") A30-31, A293-94, A703. Consistent with OPM's obligation to provide information to enrollees about coverage, FEHBA mandates that a copy of the Statement of Benefits "shall be issued" to "[e]ach individual enrollee." 5 U.S.C. § 8907(b).

Of particular relevance to this case are the terms in the Service Benefit Plan's Statement of Benefits concerning reimbursement. The Statement of Benefits provides (J.A. A785):

> If another person or entity . . . causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:

> All recoveries you obtain (whether by lawsuit, settlement, or otherwise) . . . must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees . . . .

The OPM-BCBSA contract also elsewhere directly addresses reimbursement. It requires the carrier to make "reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention." J.A. A140, A310. Furthermore, the contract mandates that all Blue Cross and Blue Shield entities "shall subrogate under a single, nationwide policy to ensure equitable and consistent treatment for all Members under the contract." *Id.*

3. *Plan Funding*. The Plan's funding is delineated both in FEHBA and OPM's regulations. The United States itself, in an amicus brief in support of Empire in the proceedings below, has succinctly detailed the Plan's fiscal operations (Pet. App. 69a):

> By statute, the government and the enrollee share responsibility for premiums payable to the plan. 5 U.S.C. § 8906. The employing agency (or OPM for annuitants) pays 72% to 75% of the premium as part of its payroll costs funded by general appropriations. *Id.* §§ 8906(b)(1), (b)(2), (f). Premiums are deposited into a special Treasury fund called the Federal Employees Health Benefits Fund. *Id.* § 8909(a).
>
> Under the type of plan at issue in this litigation, the carrier draws against the Fund on a "checks-presented" basis to pay for covered health care services. *Id.* § 8909(a); 48 C.F.R. § 1632.170(b). Any balance in the Fund is not the property of [the] carrier. Rather, the carrier's profit, if any, comes from a negotiated service charge. *See National Ass'n of Postal Supervisors v. United States*, 21 Cl. Ct. 310, 315 (1990) ("The service charge is the only profit

> element of FEHBA. * * * [The] carrier may not make a profit on the premium charges themselves."), *aff'd mem.*, 944 F.2d 859 (Fed. Cir. 1991); *see also* 48 C.F.R. § 1615.902. Any surplus in a plan's contingency reserves may be used, at OPM's discretion, to defray future rates, reduce future government and employee contributions, increase plan benefits, or refund the monies to the government and plan enrollees. 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2).

Under this fiscal regime, money collected under the Plan's reimbursement terms does not belong to the carrier, but instead inures to the government's benefit. Pursuant to the BCBSA-OPM contract, the carrier must, and does, credit all reimbursement amounts to the Treasury fund, the source for the benefits in the first place. J.A. A877. As a result, the United States has said: Because "the carrier has no property interest in any balance remaining in the Treasury fund after benefits are paid out and reimbursements received," the "requirement that enrollees reimburse the carrier for monies obtained in tort suits is . . . a critical feature of the federal health benefits program that inures to the benefit of the government." Pet. App. 74a.

4. *FEHBA's Preemption Provision.* FEHBA contains an express preemption provision, codified at 5 U.S.C. § 8902(m)(1). As amended in 1998, the preemption provision currently provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1) (2000) (codifying Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363 (1998)).

In enacting the current preemption language, which "broaden[ed]" an earlier version of the preemption clause, Congress sought to ensure "the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997) (J.A. A886). Congress added that the amendment "will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts" and "will also prevent carriers' cost-cutting initiatives from being frustrated by State laws." *Id.*

B. The Proceedings Below

Joseph McVeigh, a Plan enrollee livi g in New York, was injured in an accident in 1997. The Pla paid benefits of approximately $157,000 in connection with those injuries. Subsequently, Mr. McVeigh filed a state tort action against the third parties that allegedly caused his injuries, and his estate pursued that action after his death in 2001. His spouse and his child brought additional actions on their own behalf. In 2003, the parties to the state tort actions announced a settlement of $3,175,000.

When the estate refused to reimburse the Plan for the benefits paid to Mr. McVeigh, Empire brought suit in the United States District Court for the Southern District of New York. Seeking reimbursement of $157,000, Empire's complaint asserts claims for breach of the Plan terms and for declaratory relief. Empire invoked the district court's federal question jurisdiction, alleging that the "action is founded on [FEHBA]; on federal contracts and regulations established pursuant to FEHBA; and on federal common law." J.A. A7. The district court dismissed the case for lack of subject matter jurisdiction. Pet. App. 62a.

A divided court of appeals affirmed. Pet. App. 1a-45a. Judge Sotomayor wrote the majority opinion (*id.* at 2a-24a), with Judge Sack submitting a separate concurring opinion. *Id.* at 25a-26a. Judge Raggi dissented. *Id.* at 27a-45a.

The majority determined that federal question jurisdiction was absent because state law governed the controversy, notwithstanding FEHBA's express preemption provision. That provision states that contract terms "preempt any State or local law . . . which relates to health insurance or plans" (5 U.S.C. § 8902(m)(1)), but the majority construed the "relates to" qualifier as applying only to those state laws that *specifically* regulate health insurance or plans, excluding from FEHBA's preemptive scope state laws of general application, such as state contract law. Pet. App. 14a-19a. The majority recognized that, in interpreting similar language in the preemption provision in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a), this Court had reached an exactly opposite conclusion – namely, that state laws of general application are preempted. But the court of appeals viewed ERISA precedent as irrelevant to construing FEHBA's preemptive scope. Pet. App. 19a-21a. Judge Sotomayor added that, in her view, the preemption clause is "probably unconstitutional" as written because it provides that FEHBA *contract* provisions preempt state law; contract terms are not, she said, "Laws of the United States" capable of superseding state law within the meaning of the Supremacy Clause (U.S. Const. Art. VI, cl. 2). Pet. App. 11a.

The majority also found that federal jurisdiction could not be founded on federal common law, because it believed Empire could not satisfy the two-part test enunciated in *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988), for creating federal common law. In *Boyle*, the Court required a government contractor, in order to establish a federal common law defense in a diversity suit, to show, first, the existence of "uniquely federal interests" in the dispute and, second, a "significant conflict" between the application of state law and federal policy or objectives. *Id.* at 507-08. The majority reasoned that Empire failed the second prong of the *Boyle* test because it purportedly had not established an "actual, significant conflict with [fed-

eral] . . . interests." Pet. App. 6a-7a (internal quotation marks omitted). The majority rejected the argument that the application of state law rules would upset Congress's desire for consistent, uniform FEHBA plan administration, asserting that state contract law was "'not at its core diverse, nonuniform, and confusing.'" *Id.* at 8a (quoting *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 233 n.8 (1995)).

In his concurrence, Judge Sack wrote separately "to identify several issues that I think we do not decide." *Id.* at 25a. Among those issues was, he said, the constitutionality of FEHBA's preemption section, though he added that he found Judge Sotomayor's analysis "persuasive" and that the statute might be "*unavoidably* unconstitutional." *Id.* at 26a (emphasis in original). Judge Sack also emphasized that Empire, under *Boyle*, had plainly shown "uniquely federal interests" to be involved in its suit, but not the requisite "significant conflict." *Id.* at 25a.

Judge Raggi dissented, concluding that federal jurisdiction existed by virtue of the preemption provision. By providing for preemption, Judge Raggi explained, "Congress has identified a unique federal interest in ensuring national uniformity in the construction and enforcement of [FEHBA contract] terms." *Id.* at 35a. In addition, by amending the preemption provision in 1998 to eliminate the need for a conflict between the contract terms and state law, "Congress has implicitly authorized courts to employ federal common law to resolve disputes concerning coverage and benefits, even in the absence of the conflict generally required by *Boyle*." *Id.* Judge Raggi also rejected the majority's position that ERISA precedent should not be used to determine the reach of FEHBA's preemption provision, noting that the "statutes' preemption clauses are notably similar" and "the objectives of the two [preemption] laws are virtually identical" – namely, to ensure uniformity. *Id.* at 39a.

Empire filed a petition for rehearing and rehearing en banc. The United States, which did not participate in the proceedings

at earlier stages, filed a brief as amicus curiae supporting Empire's petition. *See* Pet. App. 65a-79a. Noting that carriers pursue reimbursement "on behalf of the United States" (*id.* at 73a), the United States argued that "suits to enforce contracts 'contemplated by federal statutes' set forth federal claims and state federal causes of action if Congress intended that the contracts be 'creations of federal law,' and that 'the rights and duties contained in those contracts be federal in nature.'" Pet. App 72a (quoting *Jackson Transit Auth. v. Local Division 1285*, 457 U.S. 15, 22-23 (1982)).

The panel denied rehearing by a 2-1 vote, issuing a supplemental opinion that reaffirmed its previous rulings on the preemption provision and the *Boyle* test. Pet. App. 46a-51a. The supplemental opinion also rejected the United States' arguments, finding that the preemption provision does not reflect the necessary Congressional intent to federalize FEHBA contract disputes when the carrier brings the action. *Id.* at 50a.

REASONS FOR GRANTING THE PETITION

The court of appeals' decision in this case creates a clear conflict with numerous other circuits, threatens to cast the administration of an important federal program into disarray, and seriously errs in both its statutory and *Boyle* analyses. The Court should grant certiorari to resolve the circuit conflict and to undo the damage engendered by the court of appeals' erroneous determination.

A. The Court of Appeals' Decision Creates Clear Conflicts in the Circuits

The court of appeals readily acknowledged that its decision conflicts with multiple decisions of other courts of appeals. On the specific question whether federal question jurisdiction exists over FEHBA reimbursement suits, the court of appeals' decision conflicts with decisions of two other circuits. In *Blue Cross & Blue Shield of Illinois v. Cruz*, 396 F.3d 793 (7th Cir. 2005), *petition for cert. filed*, No. 04-1657 (June 6, 2005), the

Seventh Circuit recently reached the opposite result in precisely the same context in which the question is presented here, holding that federal common law governs a carrier's suit to enforce the reimbursement provision in the Service Benefit Plan. The Eighth Circuit also has ruled that federal jurisdiction exists over a FEHBA plan's suit for reimbursement. *MedCenters Health Care v. Ochs*, 26 F.3d 865, 867 (8th Cir. 1994). The holding in this case cannot be squared with these decisions.

The conflict with *Cruz* is especially stark. In *Cruz*, the Seventh Circuit explained that, under the FEHBA preemption provision, 5 U.S.C. § 8902(m)(1), FEHBA contract provisions preempt state subrogation law, thus vindicating "Congress's clear intent . . . to make benefits uniform for FEHBA plan enrollees of different states." 396 F.3d at 799. The court then proceeded to hold that federal common law must govern the dispute: "With no explicit statutory cause of action on which to rely and with state law preempted, Congress's clear intent to have uniform subrogation rules per the terms of the FEHBA-created contract require a judicially-crafted cause of action." *Id.* at 799-800 (internal quotation and citation omitted). Conversely, the Second Circuit held that the preemption clause can apply only to "a specific state law or state common-law principle 'relat[ing] to health insurance,'" and therefore cannot preempt state subrogation law. Pet. App. 15a.

Although *Cruz* was decided after the Second Circuit issued its decision in this case, the Second Circuit addressed *Cruz* in the supplemental opinion issued on denial of panel rehearing, and it explicitly acknowledged that the two decisions are irreconcilable. The Second Circuit noted its "disagreement with the conclusions reached in" *Cruz* and added that the "*Cruz* court rested its holding on arguments that we addressed and squarely rejected in our original opinion." Pet. App. 50a.

More broadly, the court of appeals' crabbed construction of FEHBA's preemption clause also conflicts with decisions in other circuits involving FEHBA disputes outside of the reimbursement area. Contrary to the Second Circuit's holding

bursement area. Contrary to the Second Circuit's holding that the FEHBA preemption clause cannot encompass state "laws of general application that make absolutely no reference to health insurance or plans" (Pet. App. 16a), numerous other courts of appeals have held that FEHBA preempts state laws of general application. *See Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 806-07 (8th Cir. 1993) (state contract law); *Hayes v. Prudential Ins. Co.*, 819 F.2d 921, 926 (9th Cir. 1987) (state contract, tort, consumer protection, and fraud laws); *Blue Cross & Blue Shield of Fla., Inc. v. Dep't of Banking & Fin.*, 791 F.2d 1501, 1504-05 (11th Cir. 1986) (state unclaimed property law); *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985) (state contract law).

Furthermore, in its *Boyle* analysis, the Second Circuit's decision conflicts with *Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74 (4th Cir. 1993). The Fourth Circuit found a "significant conflict between federal interests and state law" because "[a]pplication of state law . . . would result in a patchwork quilt of benefits that varied from state to state." *Id.* at 78-79. The court specifically noted the absence of "any specific conflict between federal interest and state law," but concluded that "that fact is not important here" because "[w]hen the federal interest requires the application of a uniform rule, federal common law displaces state law entirely." *Id.* at 79. The Second Circuit, by contrast, held that a conflict is not demonstrated under *Boyle* merely where application of different state laws "would undermine the federal interest in uniformity." Pet. App. 7a. The Second Circuit acknowledged that its application of *Boyle* was irreconcilable with that of the Fourth Circuit, stating that "[t]he Fourth Circuit reached a different conclusion in *Caudill*" with respect to the uniformity analysis. *Id.*; *see also id.* at 9a ("we again part ways with the Fourth Circuit's holding in *Caudill*" with respect to state court jurisdiction over federal common law issues).

B. The Court of Appeals' Decision Potentially Throws into Disarray a Nationwide Federal Program Affecting Millions of People

It is important for this Court to grant certiorari to eliminate these conflicts and the attendant uncertainty and disparate treatment that will result if the court of appeals' decision is allowed to stand. About 8.5 million enrollees receive health benefits through FEHBA plans, encompassing the employees and annuitants (and their families) of all branches of the federal government. The FEHBA program spawns numerous disputes – involving, for instance, enrollment and coverage, as well as subrogation and reimbursement – that are litigated in courts all across the country, due to the nationwide nature of the program.

The court of appeals' decision creates a cloud of uncertainty over much of this litigation. The government, carriers, and enrollees now cannot be confident of the scope of FEHBA preemption and whether a FEHBA dispute belongs in federal or state court. In particular, they cannot predict whether FEHBA preempts state laws of general application, such as contract and tort doctrines, consumer protection laws, and anti-discrimination rules, which can be used to challenge enrollment criteria. And the court of appeals' musings that FEHBA's preemption provision might be unconstitutional raise a new threshold issue that potentially could beleaguer *every* FEHBA preemption dispute.

These uncertainties will interfere with the timely and efficient resolution of FEHBA controversies, raising the cost to enrollees and, ultimately, to the United States, which subsidizes the FEHBA program. Moreover, the court's holding that FEHBA disputes should be relegated to state court and the vagaries of state law will contravene Congress's desire that FEHBA plan benefits and administration should be uniform regardless of the enrollee's place of residence. "This situation would be fundamentally unfair to many federal employees covered by Blue

Cross contracts because enrollees in some states would pay higher premiums to cover services provided only to enrollees in other states." *Caudill*, 999 F.2d at 79. And even if the different path taken by the court of appeals is confined to the Second Circuit, there will remain a discrepancy in treatment between residents of the Second Circuit and other FEHBA enrollees.

These daunting problems are not limited to FEHBA plans. At least five other federal programs involving government benefits contain preemption provisions modeled on FEHBA's. *See, e.g.*, 5 U.S.C. § 8709 (life insurance for federal employees); *id.* § 8959 (dental benefits for federal employees); *id.* § 8989 (vision benefits for federal employees); *id.* § 9005 (long-term care insurance for federal employees); 10 U.S.C. § 1103 (health benefits for dependents of military personnel). The Court should grant certiorari to resolve the serious difficulties created by the court of appeals' decision and to prevent those difficulties from spilling into other federal benefits programs.

This Court has previously recognized the importance of resolving any jurisdictional uncertainties under the FEHBA program. In 1995, in a controversy also involving the Service Benefit Plan, the Court granted certiorari to resolve whether state law contract suits brought by enrollees against carriers to obtain FEHBA benefits involve federal questions removable to federal court. *Rocky Mountain Hosp. & Med. Serv. v. Phillips*, 513 U.S. 1071 (1995). During the pendency of that case, OPM amended its regulations to clarify that such suits can be pursued only against OPM in federal court. *See* 60 Fed. Reg. 16,037 (1995). With the jurisdictional uncertainty presumably resolved by regulation, the carrier voluntarily dismissed its case in this Court. *See Rocky Mountain Hosp. & Med. Serv. v. Phillips*, 514 U.S. 1048 (1995). Though the context now is marginally different, the concerns raised by uncertain federal jurisdiction in FEHBA disputes remains the same. As it did in *Rocky Mountain*, the Court should grant certiorari here.

C. The Court of Appeals Wrongly Concluded That the Federal Courts Lack Federal Question Jurisdiction Over Suits by Carriers to Enforce FEHBA Contract Provisions

The court of appeals erred in rejecting federal court jurisdiction in this case for at least three distinct reasons: (1) FEHBA's preemption clause displaces state laws that relate to health insurance or plans, even if the state laws are of general application, thereby leaving federal law to govern FEHBA disputes; (2) this case involves enforcement of a federal government contract entered into pursuant to FEHBA and intended by Congress to be governed by federal law; and (3) the dispute satisfies the two-part test in *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988), for the application of federal common law.

1. Federal Jurisdiction Flows from FEHBA's Preemption Provision

Federal jurisdiction lies here because of the operation of FEHBA's broad preemption clause. As originally enacted, that clause provided that FEHBA contract provisions relating to benefits and coverage "preempt any state or local law . . . which relates to health insurance or plans *to the extent that such law or regulation is inconsistent with such contractual provisions*." 5 U.S.C. § 8902(m)(1) (1994) (emphasis added). In enacting this provision, Congress was concerned that the imposition of state law requirements on FEHBA contracts "can be expected to result" in "[i]ncreased premium costs to both the Government and enrollees, and [a] lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 95-282, at 1, 4 (1977); *accord* S. Rep. No. 95-903, at 2 (1978), *reprinted in* 1978 U.S.C.C.A.N. 1412, 1413.

Subsequently, Congress determined that this preemption provision was not a sufficient bulwark against the interference of

state law in the operation of the FEHBA program. Accordingly, in 1998, Congress expanded FEHBA's preemption provision by removing the final clause requiring that there be inconsistency between state law and FEHBA contract provisions in order for there to be preemption. The preemption provision now provides simply that FEHBA contract provisions "which relate to the nature or extent of coverage or benefits (including payments with respect to benefits)" shall preempt state law "which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1) (2000).

The amendment's purpose was to "confirm[ ] the intent of Congress that . . . FEHBA program contract terms which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) *completely displace* State or local law relating to health insurance or plans." H.R. Rep. No. 105-374, at 16 (1997) (J.A. A893) (emphasis added). Likewise, as already noted, Congress intended the amendment to "strengthen the ability of national plans to offer uniform benefits and rates" and to "strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." *Id.*

The reimbursement provision in the Plan's Statement of Benefits preempts state law under this preemption clause. The reimbursement provision relates to the "extent of coverage or benefits (including payments with respect to benefits)" because it involves the return of *benefits payments* to the Plan. Absent reimbursement, the net benefits paid to an enrollee who subsequently collects from a third party would increase. In addition, state law used in the reimbursement context, whether it is a cause of action or a rule of decision, "relates to health insurance or plans," for it is being utilized to effectuate (when the Plan relies on state law) or to limit (when the enrollee relies on state law) a reimbursement requirement in an *insurance* arrangement or health *plan*. As such, the "state law claims refer to the plan, and therefore fall under the preemption clause."

Hayes v. Prudential Ins. Co., 819 F.2d 921, 926 (9th Cir. 1987).

The court of appeals rejected Empire's reading of the pre-emption provision, holding that it cannot apply to state laws of general application (such as contract law) not specifically targeted at health insurance or health plans. *See* Pet. App. 14a-23a. The court of appeals acknowledged that its construction was narrower than the interpretation this Court has given to a similar preemption provision in ERISA, which preempts state laws "insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). For example, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court held that ERISA preempts state contract and tort doctrines invoked to obtain benefits, finding state law there to have a "connection with or reference to . . . a plan." *Id.* at 47 (internal quotation marks omitted); *see also id.* at 47-48 ("In particular we have emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'") (quoting *Shaw v. Delta AirLines, Inc.*, 463 U.S. 85, 98 (1983)). Similarly, in *FMC Corp. v. Holliday*, 498 U.S. 52, 59-64 (1990), the Court interpreted the ERISA preemption provision to preempt state law subrogation doctrines.

Despite the nearly identical language in the two preemption provisions, the court of appeals stated that it was "reluctant to rely on ERISA-based precedent to justify an expansive interpretation of FEHBA's preemption provision." Pet. App. 19a. According to the court of appeals, "ERISA is significantly more comprehensive than FEHBA, in that it contains multiple preemption provisions and a detailed civil enforcement scheme." *Id.* But that is a misreading of the breadth of FEHBA's statutory and regulatory scheme: FEHBA regulates the plans it creates from cradle to grave and interposes a federal agency – OPM – to supervise all aspects of a carrier's administration of a plan. Furthermore, the court of appeals ignored that Congress was impelled to amend the FEHBA preemption

provision precisely because it was troubled by emerging court decisions holding that FEHBA's preemptive scope was narrower than ERISA's. As the Ninth Circuit explained in *Botsford v. Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390, 399 (9th Cir. 2002), "Congress amended the [FEHBA preemption] statute after numerous courts had found that FEHBA did not completely preempt state laws, but ERISA did. Thus, Congress replaced FEHBA's original preemption clause with ERISA's."

Perhaps most important, the court of appeals' decision produces the absurd result that state law plays a greater role in regulating the federal government's own health benefits plans than it does for private employer plans governed by ERISA. As the Seventh Circuit observed in *Cruz*, "if Congress intended to preempt state law when regulating private employers, it would be strange to leave regulation to the individual states when the employer is the United States itself." 396 F.3d at 799.

Because the effect of the FEHBA preemption provision is to "completely displace State or local law" (H.R. Rep. No. 105-374, at 16 (J.A. A893)), federal law fills the void and governs this lawsuit. Federal courts have the power "to declare, as a matter of common law or 'judicial legislation,' rules which may be necessary to fill in interstitially or otherwise effectuate the statutory patterns enacted in the large by Congress." *United States v. Little Lake Misere Land Co.*, 412 U.S. 580, 593 (1973); *accord Cruz*, 396 F.3d at 799-800. With state law preempted, and federal law filling the void, the district court had federal question jurisdiction over Empire's suit.

2. Federal Jurisdiction Exists Because Congress Intended that Federal Law Would Govern Suits to Enforce the Contracts Contemplated by FEHBA

Even without regard to the terms of the preemption clause, federal question jurisdiction exists here because this is a suit to enforce the terms of a government contract that Congress

contemplated would be governed by federal law. This Court long ago observed that disputes involving the "validity and construction of contracts through which the United States is exercising its constitutional functions, their consequences on the rights and obligations of the parties, the titles or liens which they create or permit, all present questions of federal law not controlled by the law of any State." *United States v. County of Allegheny*, 322 U.S. 174, 183 (1944), *overruled on other grounds, United States v. City of Detroit*, 355 U.S. 466 (1958). Hence, it is now settled that "obligations to and rights of the United States under its contracts are governed exclusively by federal law." *Boyle v. United Technologies Corp.*, 487 U.S. 500, 504 (1988) (citing *United States v. Little Lake Misere Land Co.*, 412 U.S. at 592-94; *Priebe & Sons, Inc. v. United States*, 322 U.S. 407, 411 (1947); *Clearfield Trust Co. v. United States*, 318 U.S. 363, 366-67 (1943)).

This principle ordinarily comes into play in cases in which the government is a party, but the court of appeals erred in finding the principle automatically inapplicable when the government is not a party. To the contrary, this Court emphasized in *Jackson Transit Authority v. Local Division 1285*, 457 U.S. 15, 22 (1982), that "suits to enforce contracts contemplated by federal statutes may set forth federal claims and . . . private parties in appropriate cases may sue in federal court to enforce contractual rights created by federal statutes." Indeed, federal jurisdiction can exist even where the contract is between two private parties; if the contract was specifically contemplated by federal statute, "the critical factor is the congressional intent behind the particular provision at issue." *Id.* Congress must intend that the contractual provisions "be creations of federal law" and that the "rights and duties contained in those contracts be federal in nature." *Id.* at 23 (internal quotation and citation omitted).

In *Jackson Transit*, which involved a collective bargaining agreement between a municipality and a labor union that was

contemplated by a federal funding statute, the Court concluded that state law governed the suit to enforce the contract. That conclusion was based on extensive, highly specific, legislative history that manifested Congress's clear intent that those collective bargaining agreements be governed by state law. *See id.* at 24-27. But this case stands in sharp contrast to *Jackson Transit*, and there can be little doubt that, as the United States itself argued in support of Empire on rehearing below, Congress intended FEHBA contract disputes to be governed by federal law.

Both the nature of the FEHBA contract and the subject of the lawsuit present a much stronger case here for the application of federal common law than did the contract dispute in *Jackson Transit*. While the contract in *Jackson Transit* was "contemplated" by federal statute, it was a contract between private parties. Here, although the court of appeals mistakenly characterized the contract at issue as "privately-negotiated" (Pet. App. 12a), the suit seeks to enforce a *government* contract between OPM and BCBSA. That contract was not merely "contemplated" by Congress; it and other FEHBA health benefits contracts are the essential components of the scheme created by FEHBA. Congress specified in detail in the statute what kind of contracts can be entered and the terms OPM can include in those contracts, making them "creations of federal law." *Jackson Transit*, 457 U.S. at 23; *see* 5 U.S.C. §§ 8902, 8903. Additionally, although the suit in *Jackson Transit* sought merely to vindicate a private plaintiff's rights, the suit here seeks to vindicate the rights of the United States, since it seeks funds to be returned to the Treasury under the reimbursement provision.

Empire's suit also satisfies *Jackson Transit*'s requirement that the "rights and duties contained in those contracts be federal in nature." *See* 457 U.S. at 23. The FEHBA program is purely a creation of federal law, designed to serve the interests of the federal government and its employees. FEHBA con-

tracts reflect the United States' strong interest in controlling the costs for providing health benefits to its employees and in ensuring that the level of benefits in a particular plan does not vary according to the state in which the employee resides. With respect to the reimbursement provision, the United States has an obvious interest in seeing that funds covered by that provision are returned to the U.S. Treasury. Thus, the nature of the contract at issue here is plainly federal, and FEHBA's broad preemption provision explicitly evinces Congress's intent that the contract be governed by federal law.

Indeed, even if Empire's suit rested on a state law cause of action, jurisdiction would still lie in the federal courts because the suit concerns enforcement of a federal contract that lies at the heart of an important federal program. As the Court recently reconfirmed in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 125 S. Ct. 2363, 2367 (2005), "in certain cases federal question jurisdiction will lie over state-law claims that implicate significant federal issues." If state law claims "turn on substantial questions of federal law, [the claims] justify resort to the experience, solicitude, and hope of uniformity that a federal forum offers on federal issues." *Id.* FEHBA is a federal program created by Congress that provides benefits solely to federal employees, annuitants, and their families. A substantial FEHBA contract issue embedded in a state law claim therefore belongs in federal court because its resolution there does not "disturb[ ] any congressionally approved balance of federal and state judicial responsibilities." *Id.* at 2368.

3. Federal Jurisdiction Exists Because, Under *Boyle*, Federal Common Law Controls the Case

Still another basis for federal question jurisdiction derives from the analysis in *Boyle v. United Techs. Corp.*, 487 U.S. 500 (1988). This Court has held that "§ 1331 jurisdiction will support claims founded upon federal common law." *Illinois v. Milwaukee*, 406 U.S. 91, 100 (1972). *Boyle* articulates, in turn,

a two-part test for the creation of federal common law: first, the case must implicate "uniquely federal interests," *Boyle*, 487 U.S. at 504; second, there must be a "significant conflict" between "an identifiable federal policy or interest and the [operation] of state law" or the application of state law must "frustrate specific objectives of federal legislation." *Id.* at 507 (internal quotation marks and citations omitted).

Boyle was a diversity action involving the rights and liabilities of a federal government contractor, and the Court held that federal common law applied. The plaintiffs there sued the government contractor under state law for wrongful death, where a military aircraft manufactured by the contractor had crashed, killing the pilot. Applying the first part of the test, the Court held that the suit implicated uniquely federal interests, "even though the dispute is one between private parties." *Id.* at 506. "The imposition of liability on Government contractors will directly affect the terms of Government contracts: either the contractor will decline to manufacture" the item as specified by the government or "it will raise its price. Either way, the interests of the United States will be directly affected." *Id.* at 507. With respect to the second part of the test, the Court found state law liability potentially in conflict with a policy embodied in the Federal Tort Claims Act shielding the government from liability when exercising discretionary functions, and the Court created a federal common law defense for the contractor insulating it from liability under similar circumstances.

Empire's suit here satisfies both parts of the *Boyle* test. On the first part, as Judge Sack's concurrence expressly acknowledges (Pet. App. 25a), suits for reimbursement involve uniquely federal interests. The carrier pursues such actions on behalf of the United States, in order to obtain funds inuring to the government's benefit. Indeed, the federal interest here is even stronger than in *Boyle*. Whereas in *Boyle* the uniquely federal interest was simply that the government might feel the

effects of any judgment because contractors may seek to "pass[] through" the costs of tort liability through future higher prices, the federal interest here ultimately is more concrete: the money at issue is directly credited to the Treasury and available, dollar for dollar, for the United States's use in connection with the Plan. *Boyle*, 487 U.S. at 511.

On the "conflict" prong of the analysis, the Court emphasized in *Boyle* that the conflict between the application of state law and federal policy "need not be as sharp" for the application of federal common law "as that which must exist for ordinary pre-emption when Congress legislates 'in a field which the States have traditionally occupied.'" *Id.* at 507 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). As the Court explained, the "fact that the area in question *is* one of uniquely federal concern changes what would otherwise be a conflict that cannot produce pre-emption into one that can." *Id.* at 508 (emphasis in original). The Court added that, "[i]n some cases, for example, where the federal interest requires a uniform rule, the entire body of state law applicable to the area conflicts and is replaced by federal rules." *Id.*

In this case, there is the requisite conflict between federal objectives and the operation of state law. A central policy embodied in FEHBA is the need for uniformity in FEHBA-plan administration. Indeed, Congress's stated purpose for enacting both FEHBA's original preemption provision and the amendment in 1998 was to ensure uniformity in benefits and rates. Moreover, the OPM-BCBSA contract expressly states that the carrier shall subrogate under a "single, nation-wide policy" to ensure "equitable and consistent treatment for all Members." J.A. A140, A310. The application of state law poses an unavoidable conflict with the federal objective of uniformity. The Fourth Circuit cogently expressed this point when it upheld federal court jurisdiction over FEHBA disputes in *Caudill v. Blue Cross & Blue Shield of North Carolina, Inc.*, 999 F.2d 74, 79 (4th Cir. 1993): "As an employer, the federal

government has an overwhelming interest in ensuring that all of its employees subject to a particular health insurance policy are treated equally regardless of the state in which they live, and the application of state law interferes with this interest."

The court of appeals did not question that Empire's action involved uniquely federal interests. Nor did it dispute the federal goal of uniformity in FEHBA-plan administration. Rather, seizing on this Court's observation in a footnote in *American Airlines, Inc. v. Wolens*, 513 U.S. 219, 233 n.8 (1995), that contract law is "not at its core diverse, nonuniform, and confusing," the court of appeals erroneously held that there is no conflict here between the federal objective of uniformity and the application of state contract law. However, because this case involves uniquely federal interests, the conflict necessary for the displacement of state law need not be as pronounced as would be required for preemption in areas where, as in *Wolens*, there typically is a heavy presumption against preemption. The court of appeals erred in resolving the conflict issue by reference to a statement in a preemption case like *Wolens*, where no uniquely federal interests were at issue.

In any event, it is not just state contract law that is relevant to reimbursement actions. State law on *subrogation* is undeniably diverse, with some states forbidding subrogation entirely. *See* Patricia G. Tobin, *The Rawlings & Assocs. National Subrogation Law Manual 1998*, at 51-53 (1997); *see also Cruz*, 396 F.3d at 796, 800-01 (Illinois common fund doctrine asserted as partial defense to reimbursement claim); *MedCenters Health Care v. Ochs*, 26 F.3d 865, 867 (8th Cir. 1994) (Minnesota "full-recovery rule" asserted as defense to reimbursement claim). Federal common law must govern a FEHBA carrier's action for reimbursement to ensure that divergent state rules on subrogation do not thwart the uniform administration Congress intended.

In sum, because FEHBA reimbursement is an area of uniquely federal concern and the operation of state law in

reimbursement disputes conflicts with the Congressional desire for uniformity, Empire has satisfied the *Boyle* test. Federal common law therefore controls the dispute, meaning that it raises a federal question.

D. The Court Should Resolve the Circuit Conflict by Granting Certiorari in This Case

As already noted, the court of appeals' decision in this case directly conflicts with the Seventh Circuit's decision in *Blue Cross & Blue Shield of Illinois v. Cruz*, 396 F.3d 793 (7th Cir. 2005), *petition for cert. filed*, No. 04-1657 (June 6, 2005). We believe that Empire's action presents a better vehicle for resolving the circuit conflict than does *Cruz* and, accordingly, submit that the Court should grant certiorari in this case rather than *Cruz* for the purpose of reviewing the issues.

The question whether federal jurisdiction exists over a carrier's suit to enforce the Plan's reimbursement terms is cleanly presented in this case. In *Cruz*, there are parallel state court proceedings that the *Cruz* petitioner insists complicate resolution of the federal case. Indeed, petitioner's "Questions Presented" in *Cruz* occupy an entire page and emphasize whether federal jurisdiction exists "where a state court action was already proceeding on the issue." Pet. for Writ of Cert., *Cruz*, No. 04-1657, at *i* (June 6, 2005). Although we believe the Seventh Circuit correctly ruled in *Cruz* that the parallel state court action does not affect federal jurisdiction, Empire's case avoids the issue altogether because it has no competing state court proceedings.

In addition, the Second Circuit decision portends greater mischief befalling the FEHBA program. The Seventh Circuit's *Cruz* opinion is a sparer decision, nowhere seeking to draw a distinction between laws of general and specific application for preemption purposes, nowhere questioning the constitutionality of FEHBA's preemption clause, and principally addressing only preemption as a basis for federal jurisdiction (and only briefly addressing *Boyle*). In light of the more numerous deci-

sional bases invoked by the Second Circuit, some of which might be deemed to remain intact even if the Court were to grant the petition in *Cruz* and affirm, the Court should review the Second Circuit's determination.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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AUGUST 2005

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

August Term, 2003

(Argued: May 15, 2004 Decided: January 14, 2005)

Docket No. 03-3098

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross and Blue Shield,

Plaintiff-Appellant,

v.

DENISE FINN MCVEIGH, as administratrix of the Estate of Joseph E. McVeigh,

Defendant-Appellee.

Before: SACK, SOTOMAYOR and RAGGI, *Circuit Judges.*

Empire HealthChoice Assurance, Inc. ("Empire") appeals from a judgment entered in the United States District Court for the Southern District of New York (Cote, J.) dismissing for lack of subject matter jurisdiction Empire's claims against Denise Finn McVeigh for reimbursement of insurance benefits. Because the Federal Employees Health Benefits Act does not contain an affirmative grant of authority to federal courts to make federal common law, and

because there is no demonstrated conflict with state law that would require federal common-law rule-making in this case, we find that Empire's contract claims arise under state law.

AFFIRMED.

Judge Sack concurs in Judge Sotomayor's opinion and in a separate opinion. Judge Raggi dissents in a separate opinion.

SOTOMAYOR, *Circuit Judge*:

Empire HealthChoice Assurance, Inc. ("Empire") appeals from a judgment entered in the United States District Court for the Southern District of New York (Cote, J.) dismissing for lack of subject matter jurisdiction Empire's contract action against Denise McVeigh, as administratrix of Joseph McVeigh's estate, for reimbursement of insurance benefits. Because the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914, does not affirmatively authorize the creation of federal common law in this case, federal common-law rule-making is only appropriate if the operation of state law would "'significant[ly] conflict'" with "uniquely federal interest[s]." *Boyle v. United Techs. Corp.*, 487 U.S. 500, 507, 508 (1988). Because no such conflict has been demonstrated in this dispute, Empire's action arises under state, not federal, law. Accordingly, we affirm the district court's dismissal of the action for lack of subject matter jurisdiction. *See* 28 U.S.C. § 1331; *Empire HealthChoice Assurance v. McVeigh*, No. 03 Civ. 2728, 2003 WL 22171693 (S.D.N.Y. Sept. 18, 2003).

BACKGROUND

The Federal Employees Health Benefits Act ("FEHBA") charges the United States Office of Personnel Management ("OPM") with negotiating and regulating health benefits plans for federal employees. *See* 5 U.S.C. § 8902(a). Pursuant to FEHBA, OPM entered into a contract in 1960 with the Blue Cross and Blue Shield Association

("BCBSA") to establish a nationwide fee-for-service health plan (the "Plan"), the terms of which are renegotiated annually.[1] Plaintiff-appellant Empire is the entity that administers the Plan to federal employees in New York State.

Defendant-Appellee Denise Finn McVeigh ("McVeigh") administers the estate of Joseph E. McVeigh ("Decedent"), a former enrollee in the Plan. The Decedent suffered injuries in an accident in 1997 and received $157,309.06 in benefits from the Plan between 1997 and 2001, the year of his death. McVeigh subsequently brought state tort actions on behalf of herself, the Decedent and a minor child against the parties who had allegedly caused Decedent's injuries. McVeigh received $3,175,000 when the lawsuit settled in 2003.

Prior to the entry of the settlement, Empire became aware of the agreement and notified McVeigh that it had a lien on the Decedent's share of the settlement for $157,309.06. McVeigh agreed to place $100,000 of the Decedent's share of the settlement funds into escrow pending resolution of Empire's claims.

On April 18, 2003, Empire filed suit against McVeigh for $157,309.06 in the United States District Court for the Southern District of New York. The complaint was based on a subrogation and reimbursement provision contained in the Statement of Benefits of the Plan. Under this provision, an enrollee who receives benefits in connection with an injury

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[1] The contract is negotiated between OPM and BCBSA. Federal employees like Joseph McVeigh do not enter into a contract for health benefits with BCBSA or any other Blue Cross and Blue Shield entity, but instead enroll in the Plan pursuant to the contract between BCBSA and OPM. While OPM is a party to the FEHBA contract, we emphasize that the dispute in this case is between two private parties: Empire and Denise Finn McVeigh.

in addition to compensation from a third party must reimburse the Plan the amount of benefits paid.[2] Empire's complaint alleged that McVeigh breached this provision and sought a judgment declaring that pursuant to the Plan, FEHBA, its regulations and federal common law, Empire was entitled to reimbursement from McVeigh for the amount of benefits paid for Decedent's injuries.

McVeigh moved for dismissal of the action on the grounds that, *inter alia*, the district court lacked subject matter jurisdiction. In response, Empire claimed that the court had jurisdiction under 28 U.S.C. § 1331 because federal common law governed its reimbursement claim. In the alternative, Empire argued that the Plan itself constituted federal law. District Court Judge Denise Cote rejected both of Empire's theories and granted McVeigh's motion to dismiss for lack of subject matter jurisdiction on September 18, 2003. *See Empire HealthChoice Assur.*, 2003 WL 22171693, at *3-*5.

DISCUSSION

A.

We review *de novo* a district court's legal conclusions with respect to its subject matter jurisdiction. *Gualandi v. Adams*,

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[2] The provision provides in relevant part:

> If another person or entity . . . causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:
>
> All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.

385 F.3d 236, 240 (2d Cir. 2004). Empire claims that federal jurisdiction exists pursuant to 28 U.S.C. § 1331, which grants federal district courts original jurisdiction over "all civil actions arising under the Constitution, laws, or treaties of the United States." Section 1331 jurisdiction -- that is, federal question jurisdiction -- "exists where a well-pleaded complaint 'establishes either that federal law creates the cause of action or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law.'" *Greenberg v. Bear, Stearns & Co.*, 220 F.3d 22, 25 (2d. Cir. 2000) (quoting *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 27-28 (1983)); *see also Marcus v. AT&T Corp.*, 138 F.3d 46, 52 (2d Cir. 1998). Though the plaintiff is generally "the master of the complaint," *id.*, a plaintiff cannot create federal jurisdiction under § 1331 simply by alleging a federal claim where in reality none exists. *See Perpetual Securities, Inc. v. Tang*, 290 F.3d 132, 137 (2d Cir. 2002). Subject matter jurisdiction will lie only where the court determines that "'the substance of [the plaintiff's] allegations raises a federal question.'" *D'Alessio v. New York Stock Exchange, Inc.*, 258 F.3d 93, 100 (2d Cir. 2001) (emphasis omitted) (citation omitted). The existence of a federal question must be determined solely by reference to the plaintiff's own claim -- not by reference to "statements raised in anticipation or avoidance of possible defenses that may be interposed." *Briarpatch Ltd., L.P v. Phoenix Pictures, Inc.*, 373 F.3d 296, 304 (2d Cir. 2004); *see also Caterpillar Inc. v. Williams*, 482 U.S. 386, 393 (1987).

FEHBA does not provide a federal statutory cause of action for insurance carriers to vindicate their rights under FEHBA-authorized contracts. Thus, federal jurisdiction exists over this dispute only if federal common law governs Empire's claims. *See Woodward Governor Co. v. Curtiss-Wright Flight Sys., Inc.*, 164 F.3d 123, 126 (2d Cir. 1999)

("It is beyond dispute that if federal common law governs a case, that case presents a federal question within the subject matter jurisdiction of the federal courts, just as if the case were governed by a federal statute."). The ability of federal courts to fashion federal common law, however, is "severely limited." *In re Gaston & Snow*, 243 F.3d 599, 606 (2d Cir. 2001); *see also O'Melveny & Myers v. FDIC*, 512 U.S. 79, 87 (1994) (stating that the "cases in which judicial creation of a special federal rule would be justified . . . are . . . few and restricted" (citation and internal quotation marks omitted)). Absent congressional authorization, *see Texas Indus. v. Radcliff Materials, Inc.*, 451 U.S. 630, 641 (1981), courts may only create federal common law where the operation of state law would (1) "'significant[ly] conflict'" with (2) "'uniquely federal interests,'" *Boyle v. United Techs. Corp.*, 487 U.S. 500, 507, 508 (1988); *see also O'Melveny*, 512 U.S. at 87; *Woodward*, 164 F.3d at 127. These circumstances were present, for instance, in *Boyle*, where the Supreme Court held that federal common law provided a defense shielding a federal defense contractor from liability under state law for defective design. 487 U.S. at 509-12. The "state-imposed duty of care," the Court found, was "precisely contrary" to a duty imposed by the government contract. *Id.* at 509.

Empire argues that its contract dispute with McVeigh satisfies the "uniquely federal interests" prong of *Boyle*. Reimbursement, Empire explains, directly affects the United States Treasury and the cost of providing health benefits to federal employees. Moreover, Empire contends, Congress has expressed its interest in maintaining uniformity among the states with respect to the benefits of its health plans.

We need not address these arguments, because we find that regardless of the strength or importance of the federal interests at stake, Empire has failed to demonstrate that the operation of New York state law creates an "an actual,

significant conflict" with those interests. *Woodward*, 164 F.3d at 127; *see also id.* ("[I]n disputes between two private parties, federal courts . . . have shown a marked reluctance to displace state law by finding a significant conflict with a federal interest."). Tellingly, Empire's briefs on appeal fail to mention a single state law or state-imposed duty that runs contrary to the federal interests asserted in this case.

Because it cannot identify any way in which the operation of state law creates an actual conflict, Empire is left to speculate about the various harms that "might" result from state-by-state adjudication of suits brought by insurance carriers under FEHBA-authorized contracts. Empire argues, for example, that state law would undermine the federal interest in uniformity because enrollees in some states "might" successfully avoid reimbursement while others would have to repay. Empire also contends that uncertainties associated with the application of state law "might" reduce the source of funds available to defray overall costs of paying benefits. These speculations do not suffice to satisfy the conflict prong of *Boyle*. *See Woodward*, 164 F.3d at 127 ("[A]n actual, significant conflict between a federal interest and state law must be specifically shown, and not generally alleged." (internal quotation marks and citation omitted)).

The Fourth Circuit reached a different conclusion in *Caudill v. Blue Cross & Blue Shield of North Carolina, Inc.*, 999 F.2d 74 (4th Cir. 1993). The *Caudill* court found that the application of state law "would result in a patchwork quilt of benefits that varied from state to state under the same contract because of the vast differences in the common law of contracts from state to state." *Id.* at 79. Thus, the court held that the case presented a significant conflict between the federal interest in uniformity and state law. *Id.*; *see also id.* at 79 ("[T]he very application of state contract law would undermine the uniformity envisioned by Congress when it delegated the authority to interpret health benefit contracts to

OPM."). The *Caudill* court, however, cited no sources for its sweeping claim that "vast difference[s]" existed in the common law of contracts among the states. *Id.* The Supreme Court reached the opposite conclusion less than two years later in a dispute involving the Airline Deregulation Act of 1978. *See American Airlines, Inc. v. Wolens*, 513 U.S. 219, 233 n.8 (1995). In *Wolens*, the Court observed that "[b]ecause contract law is not at its core diverse, nonuniform, and confusing," there was "no large risk of nonuniform adjudication inherent in [s]tate-court enforcement of the terms of a uniform agreement prepared by an airline and entered into with its passengers nationwide." *Id.* (second alteration in original) (internal quotation marks and citations omitted). In light of *Wolens*, we see no reason to *assume* as a general matter that a conflict necessarily exists between the operation of state contract law and the federal interests in uniformity underlying FEHBA. Because Empire has not demonstrated an "actual, significant" conflict between New York state law and the federal interests underlying FEHBA, *see Woodward*, 164 F.3d at 127, we hold that the dispute between Empire and McVeigh fails to satisfy the conflict prong of *Boyle*.

B.

We recognize the possibility that at a later stage in the proceedings, a significant conflict might arise between New York state law and the federal interests underlying FEHBA, such that the dispute would satisfy both prongs of *Boyle*. If, for example, McVeigh were to defend herself in reliance upon a state law that was meant to advance a particular state policy, Empire could argue that such state law—whether statutory or common law—conflicts with federal interests and requires the application of federal common law. This possibility, however, is insufficient to confer federal jurisdiction. *See Briarpatch Ltd.*, 373 F.3d at 304 ("The claims established by the well-pleaded complaint must

necessarily be determined from the plaintiff's statement of his or her own claim, *not including statements raised in anticipation or avoidance of possible defenses that may be interposed.*") (emphasis added); *see also Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2494 (2004); *City of Rome v. Verizon Communications Inc.*, 362 F.3d 168, 177 (2d Cir. 2004). Thus, it would be up to the state court to apply federal common law. *See Charles Dowd Box Co., Inc. v. Courtney*, 368 U.S. 502, 507-508 & n.4 (1962) (stating that state courts are competent to enforce federal rights and noting that "[i]ndeed, Congress has so arranged the limited jurisdiction of federal courts that some federal laws can be enforced only in state courts." (citations omitted)); *see also Local 174, Teamsters, Chauffeurs, Warehousemen & Helpers v. Lucas Flour Co.*, 369 U.S. 95, 103-04 (1962) (holding that a state court exercising jurisdiction over suit arising from collective bargaining agreement must apply federal common law).

By finding that satisfaction of the two-prong *Boyle* test does not necessarily create federal jurisdiction under 28 U.S.C. § 1331, we again part ways with the Fourth Circuit's holding in *Caudill*. The *Caudill* court conflated the preemption and jurisdiction analyses by holding that a significant conflict with uniquely federal interests was sufficient to confer subject matter jurisdiction on the federal court.[3] *See* 999 F.2d at 78-79. We agree with the criticism *Caudill* has received for giving short shrift to the well-pleaded complaint rule. *See Goepel v. Nat'l Postal Mail Handlers Union*, 36 F.3d 306, 314-15 (3d Cir. 1994) (rejecting *Caudill*'s reasoning); 15 James Wm. Moore, et al., *Moore's Federal Practice* § 103.45[3][c] (3d ed. 2004)

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[3] In *Boyle*, the Court did not refer to the well-pleaded complaint rule because jurisdiction was based on the parties' diversity. *See* 487 U.S. at 502.

(commenting that *Caudill* is "fatally flawed if the validity of the pleaded complaint rule . . . [is] accepted").[4]

C.

Empire also argues -- and our dissenting colleague agrees -- that federal jurisdiction exists pursuant to FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1).[5] Before explaining why we disagree, we discuss first a peculiar feature of § 8902(m)(1) which receives very little judicial attention. Though courts generally decide FEHBA cases as if § 8902(m)(1) were a preemption provision like any other, *see, e.g.*, *Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 926 (9th Cir. 1987) (discussing earlier version of § 8902(m)); *Blue Cross & Blue Shield of Fla., Inc. v. Dep't of Banking and Fin.*, 791 F.2d 1501, 1504-05 (11th Cir. 1986) (same), the provision is in fact quite unusual, because it provides that certain types of *contract terms* will "supersede

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[4] Nothing in this analysis contravenes our decision in *Woodward*, 164 F.3d 123. *Woodward* did not go so far as to hold that satisfaction of *Boyle* provides federal question jurisdiction. Instead, it held that where the plaintiff fails to satisfy *Boyle* there is clearly no basis for federal question jurisdiction. There is nothing in the case that precludes us from clarifying that, even in cases in which *Boyle* is satisfied, courts must still ask the secondary question of whether the federal common law issue appears on the face of the plaintiff's well-pleaded complaint.

[5] Section 8902(m)(1) provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

and preempt" state laws in a particular field. 5 U.S.C. § 8902(m)(1). Normally, preemption clauses provide that federal *law* will preempt state law. A typical provision might provide for preemption, for example, by expressly stating that the statute's provisions preempt state law, *see, e.g.*, Employee Retirement Income Security Act (ERISA) § 514(a), 29 U.S.C. § 1144(a); 1976 Copyright Act § 301, 17 U.S.C. § 301(a), or by prohibiting state law from interfering with a policy established in federal law, *see, e.g.*, Communications Act § 253, 47 U.S.C. § 253. Regardless of a given provision's structure or wording, however, we generally take for granted that it is *law*, and not a mere contract term, that carries the preemptive force. *See generally Sprint Spectrum L.P. v. Mills*, 283 F.3d 404, 414-16 (2d Cir. 2002) (summarizing preemption doctrine).

Though § 8902(m)(1)'s plain language differs from typical preemption provisions by unambiguously providing for preemption by contract, such a literal reading of the provision is highly problematic, and probably unconstitutional, because only federal law may preempt state and local law. The constitutionality of federal preemption is, after all, grounded in the Supremacy Clause of the Constitution, which provides that "*the Laws of the United States* . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. Art. VI, cl. 2. (emphasis added); *see Sprint Spectrum*, 283 F.3d at 414-15 ("The foundation of preemption doctrines is the Supremacy Clause, which invalidates state laws that interfere with, or are contrary to, federal law." (citations, alterations and internal quotation marks omitted)). There is no constitutional basis for making the terms of contracts with private parties similarly "supreme" over state law. *See Arthur D. Little, Inc. v. Comm'r of Health and Hosps.*, 481 N.E.2d 441, 452 (Mass. 1985) ("[T]his court has been unable

to locate authority in this or any other jurisdiction which supports the proposition that a contract to which the Federal government is a party somehow constitutes Federal law for the purposes of the supremacy clause.").

Taken literally, therefore, FEHBA's preemption provision may fail to withstand constitutional scrutiny unless FEHBA-authorized contracts themselves are "Laws of the United States." They are not. "Law" connotes a policy imposed by the government, not a privately-negotiated contract. See *Wolens*, 513 U.S. at 229 n.5 (1995) (finding that "the word series 'law, rule, regulation, standard, or other provision'" as used in a federal statute "connotes official, government-imposed policies, not the terms of a private contract." (citation and internal quotation marks omitted)); *see also id.* at 241 (O'Connor, J., concurring in the judgment in part and dissenting in part) ("To be sure, the terms of private contracts are not 'laws' . . . ."). Under FEHBA, the government does not impose contract terms as it would impose a law. Rather, the OPM negotiates the contract terms privately with insurance providers, *see generally Doe v. Devine*, 703 F.2d 1319, 1321-23 (D.C. Cir. 1983), who are under no obligation to enter into the contracts in the first place. *Cf. Evanns v. AT&T Corp.*, 229 F.3d 837, 840 n.9 (9th Cir. 2000) ("'[A] tariff, required by law to be filed, is not a mere contract. It is the law.'" (quoting *Carter v. Am. Tel. & Tel. Co.*, 365 F.2d 486, 496 (5th Cir.1966))); *Marcus v. AT&T Corp.*, 138 F.3d 46, 56 (2d Cir. 1998) (distinguishing between laws and "mere contracts") (internal quotation marks and citation omitted). Empire's attempt to portray FEHBA contracts as "law" is unavailing.[6]

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[6] In arguing that the contract terms constitute law, Empire relies on *Marcus*, in which this Court found that federal tariffs filed by AT&T with the FCC were themselves federal law. See 138 F.3d

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The fact that a literal reading of § 8902(m)(1) raises serious constitutional problems does not, however, require us to invalidate the provision. "[W]here an otherwise acceptable construction of a statute would raise serious constitutional problems," we may "construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988). This canon of statutory construction, known as "constitutional avoidance," is grounded in "respect for Congress, which we assume legislates in the light of constitutional limitations." *United States v. Pettus*, 303 F.3d 480, 486 (2d Cir. 2002) (citation and internal quotation marks omitted). Here, we can reasonably construe § 8902(m)(1) as requiring that, in cases involving the "terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits," *federal law* "shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). This construction is as faithful as constitutionally possible to the provision's plain language and respects Congress's stated intent to maintain "uniformity" in FEHBA benefits and to "displace State or local law relating to health insurance or plans." H.R. Rep. No. 105-374, at 9, 16 (1997); see also S.

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at 56. *Marcus*, however, relied on an entire body of law standing for the proposition that "federal tariffs are the law, not mere contracts." Id. (citation and internal quotation marks omitted). There is no comparable case law surrounding FEHBA-authorized contracts. Moreover, AT&T was required by law to file the tariffs that were at issue in *Marcus*. This makes the tariffs fundamentally different from a FEHBA contract, which the government does not impose but rather negotiates with willing insurance companies.

Rep. No. 105-257, at 15 (1997). The federal law preempting state law may be federal common law or the FEHBA statute provisions themselves, but it must be law -- not contract terms.

D.

Turning to the effect of § 8902(m)(1) on the instant case, we disagree with the argument put forth by Empire and the dissent that the provision somehow authorizes by itself the exercise of federal jurisdiction. In our view, § 8902(m)(1), which makes no reference to a federal right of action or to federal jurisdiction, is simply a limited preemption clause that the instant dispute does not trigger.[7] Reading § 8902(m)(1) as conferring federal jurisdiction over contract disputes between private parties strains the language of the

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[7] Notably, FEHBA does contain a provision authorizing federal jurisdiction over FEHBA-related civil actions or claims "*against the United States*." 5 U.S.C. § 8912 (emphasis added). Of course, the grant of federal jurisdiction over one category of claims does not necessarily strip federal courts of their jurisdiction over another category of claims. *See Verizon Maryland, Inc. v. Pub. Serv. Comm'n*, 535 U.S. 635, 643-44 (2002). Nevertheless, § 8912 does demonstrate that Congress considered jurisdictional issues in enacting FEHBA and did not hesitate expressly to confer federal jurisdiction where it found it necessary to do so.

The OPM has also moved to expand federal jurisdiction. As noted by our dissenting colleague, the OPM modified FEHBA regulations in 1995 to provide that legal actions seeking review of final action by the OPM for a denial of health benefits "must be brought against OPM and not against the carrier or carrier's subcontractors." 5 C.F.R. § 890.107. Read together with 5 U.S.C. § 8912, the new regulation ensures that suits brought by beneficiaries for denial of benefits will land in federal court. There is, however, no analogous regulation opening federal courts to insurance carriers seeking reimbursement from beneficiaries.

provision and undermines the presumption against federal preemption that should guide our analysis in this case. *See Gerosa v. Savasta & Co.*, Inc., 329 F.3d 317, 323 (2d Cir. 2003) (noting that there is an "assumption that Congress does not intend to supplant state law" (citation and internal quotation marks omitted)).

Two independent conditions must be satisfied in order to trigger preemption under § 8902(m)(1). First, preemption only occurs when the FEHBA contract terms at issue "relate to the nature, provision, or extent of coverage or benefits." 5 U.S.C. § 8902(m)(1). Second, federal law may only preempt state or local laws if those laws "relate[] to health insurance or plans."[8] *Id.* Empire completely ignores the existence of this second condition, arguing erroneously that because the contract provisions at issue relate to benefits, they necessarily supersede "all state law." Without any showing that the dispute implicates a specific state law or state common-law principle "relat[ing] to health insurance," § 8902(m)(1) does not authorize federal preemption of state law in this case.[9]

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[8] We agree with Empire that the District Court erroneously relied on a version of the preemption provision that is no longer in effect. *See Empire HealthChoice Assur.*, 2003 WL 22171693, at *3. Even applying the proper provision, however, Empire's argument fails.

[9] The suit will certainly trigger FEHBA's preemption provision at a later stage if McVeigh defends herself by reference, for example, to a state health insurance law. Such a possibility of preemption, however, is insufficient to establish federal jurisdiction. As discussed in Section B, *supra*, the well-pleaded complaint rule precludes a party from invoking federal jurisdiction merely because it anticipates a defense that will be preempted by federal law. *Briarpatch Ltd.*, 373 F.3d at 304; *see also Davila*, 124 S. Ct. at 2494; *City of Rome*, 362 F.3d at 177. If McVeigh does not defend in reliance upon some state law relating to health

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Judge Raggi argues in dissent that the case satisfies the second condition for § 8902(m)(1) preemption on the ground that the phrase "state or local law . . . which relates to health insurance or plans" encompasses laws of general application that make absolutely no reference to health insurance or plans but are used in a given case to "construe or enforce" FEHBA plans. *Post* at **[14]**. In our view, this reading of § 8902(m)(1), renders the second limiting condition meaningless. This is because *every* state or local law applied to a dispute satisfying the first condition (that is, every state law applied to a dispute involving a contract term relating to coverage or benefits) will ipso facto affect the construction or enforcement of that term. Thus, under the dissent's reasoning, FEHBA contract terms will preempt every state or local law so long as the first requirement is satisfied. This strips the second limiting condition of any force whatsoever.[10]

Judge Raggi contests this characterization of her analysis, explaining that under her interpretation, the second limiting condition might still impose meaningful limits on

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insurance, or in reliance on some state common law principle that would clearly run counter to federal policy, then state law could resolve whether McVeigh has breached her obligations. *See Wallis v. Pan Am Petroleum Corp.*, 384 U.S. 63, 71 (1966) (finding no authority to fashion federal common law where "there has been no showing that state law is not adequate to achieve" the federal interest).

[10] If Congress had not wished to limit the types of state laws subject to preemption, it could have quite easily provided that "federal law shall govern the interpretation and enforcement of contract terms under this chapter which relate to the nature, provision, or extent of coverage or benefits."

preemption "where general state or local law affects FEHBA coverage or benefits only tangentially, without attempting to construe or enforce those plan terms." *Post* at **[15]**. Even in such circumstances, however, the second limiting condition would likely have no meaning that is independent and distinct from the *first* limiting condition, which requires that the contract terms at issue specifically relate to health coverage in order for preemption to occur. 5 U.S.C. § 8902(m)(1). In other words, under the circumstances described by Judge Raggi, in which FEHBA coverage is only affected "tangentially," it is highly unlikely that *either* condition for § 8902(m)(1) preemption will be met. Thus, Judge Raggi's argument does not explain how the second limiting condition carries any independent meaning. Perhaps, under Judge Raggi's interpretation, the second condition might have independent meaning in a dispute that (1) centers on contract terms specifically relating to health coverage but (2) does not involve the enforcement or construction of those contract terms. We find it difficult, however, to imagine such a case.[11]

In defense of her position, Judge Raggi observes that many Supreme Court and Second Circuit cases construe the term

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[11] Judge Raggi's discussion of ERISA-related precedent on this point does not support her argument, because ERISA contains no provision that is analogous to the first limiting condition contained in 5 U.S.C. § 8902(m)(1). *See post* at **[15]** (citing *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 660-661 (1995)); 29 U.S.C. § 1144(a). Thus, while the cases cited by Judge Raggi demonstrate that § 8902(m)(1)'s second condition, as she interprets it, might impose meaningful limits on preemption, they do not demonstrate that the second condition imposes any limits not already imposed by the first condition.

"relates to" quite broadly. *See post* at **[12-13]**. The cases she cites, however, are not directly applicable because they did not involve FEHBA. As this Court, our sister circuits and the Supreme Court have all recognized, the precise meaning of the vague term "relates to" depends on the larger statutory context. *See, e.g., Gerosa*, 329 F.3d at 323 (stating that "ERISA's nearly limitless 'relates to' language offers no meaningful guidelines to reviewing judges," and that we must therefore "'go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive'" (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655-56 (1995))); *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 850 (9th Cir. 2002) ("'[R]elates to' must be read in the context of the presumption that in fields of traditional state regulation the historic police powers of the States [are] not to be superseded by [a] Federal Act unless that was the clear and manifest purpose of Congress. Here, this means that we must presume that Congress did not intend [FEHBA] to preempt the quintessentially state-law standards of reasonable medical care, because § 8902(m)(1) does not indicate a clear and manifest intent to preempt this area of state law." (second and third alterations in original) (citations and internal quotation marks omitted)). The Supreme Court has specifically warned against overly-broad interpretations of the term, noting that "[i]f 'relate[s] to' were taken to extend to the furthest stretch of its indeterminancy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere." *Travelers Ins. Co.*, 514 U.S. at 655 (citation and internal quotation marks omitted). To define "relate[s] to" so broadly "would be to read Congress's words of limitation as

mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality." *Id.*[12]

We should be especially reluctant to rely on ERISA-based precedent to justify an expansive interpretation of FEHBA's preemption provision, given the fundamental differences between ERISA and FEHBA. ERISA is significantly more comprehensive than FEHBA, in that it contains multiple preemption provisions and a detailed civil enforcement scheme intended to completely supplant state law. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The Supreme Court has relied heavily on ERISA's civil enforcement provisions, as well as those provisions' unambiguous legislative history, to support holdings that broadly construe ERISA's preemptive reach. *See Davila*, 124 S. Ct. at 2500 (stating that the Court's understanding of

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[12] Judge Raggi explains that "relate to" is "synonymous with the phrases 'in connection with,' 'associated with,' 'with respect to,' and 'with reference to.'" *Post* at **[12]**. The Supreme Court, however, has recognized the limited usefulness of such definitions. In *Travelers Insurance Co.*, a case involving ERISA, the Court wrote:

> [We must determine] whether the surcharge laws have a "connection with" the ERISA plans, and here an uncritical literalism is no more help than in trying to construe "relate to." For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.

514 U.S. at 656.

ERISA's preemptive effect is informed by the "overpowering federal policy" embodied in ERISA's civil enforcement provision, which was intended to create "an exclusive federal remedy"); *Pilot Life*, 481 U.S. at 55 (quoting the ERISA Conference Report's statement that all suits to enforce benefits rights "are to be regarded as arising under the laws of the United States") (emphasis omitted); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) (noting that ERISA's "deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern" (citation and internal quotation marks omitted)); *Pilot Life*, 481 U.S. at 46 (noting ERISA sponsors' emphasis on the "breadth and importance of [ERISA's] preemption provisions"). Given ERISA's comprehensive civil enforcement mechanisms and a legislative history "fully confirm[ing]" that ERISA's remedies were meant to be exclusive, *Pilot Life*, 481 U.S. at 54, we reject Empire's and Judge Raggi's suggestion that we should rely on ERISA-related precedent to determine the preemptive reach of FEHBA. *See Ingersoll-Rand Co.*, 498 U.S. 133; *Devlin v. Transp. Communications Int'l Union*, 173 F.3d 94, 98 (2d Cir. 1999).[13]

The non-ERISA cases on which Judge Raggi relies in her dissent similarly fail to justify the excessively broad interpretation of "relate to" that she favors. In *Coregis*

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[13] Furthermore, Judge Raggi may overstate the degree to which FEHBA's preemption provision is similar to ERISA's. In comparing the wording of the two provisions, Judge Raggi omits mention of the first limiting condition of 5 U.S.C. § 8902(m)(1), which requires that the preempting contract term "relate to . . . [health] coverage or benefits." *See post* at **[14]**. ERISA's provision contains no analogous requirement. *See* 29 U.S.C. § 1144(a); *see also* note 11, *supra*.

Insurance Co. v. American Health Foundation, Inc., 241 F.3d 123 (2d Cir. 2001), for example, the issue was whether certain lawsuits were "related to" a company's financial failure within the meaning of an insurance policy. We noted that the "[l]awsuits are related to the Companies' financial failure by the very wording of the complaints, which explicitly refer to, discuss, and seek redress for that failure." *Id.* at 131. In the instant case, neither Empire nor Judge Raggi has cited any state law that "explicitly refers to" or "discuss[es]" health insurance or plans. *Coregis*'s rationale therefore does not apply.[14]

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[14] Judge Raggi also cites *Celotex Corp. v. Edwards*, 514 U.S. 300 (1995) and *Kamagate v. Ashcroft*, 335 F.3d 144 (2d Cir. 2004). *See post* at **[12]**. In interpreting the term "relate to" in *Celotex*, however, the Supreme Court did not have to contend with the general presumption against federal preemption. On the contrary, the Court analyzed the term with the understanding that "Congress intended to grant *comprehensive* jurisdiction to the bankruptcy courts so that they might deal efficiently and expeditiously with *all matters* connected with the bankruptcy estate." *Id.* at 308 (emphasis added) (citations and internal quotation marks omitted). *Kamagate* also fails to support Judge Raggi's argument because it involved a context in which Congress intended to give the term "relate to" an expansive meaning. *See Kamagate*, 385 F.3d at 154 ("Congress intended to give inclusive meaning in the immigration laws to the phrase 'relating to.'" (quoting *In re Beltran*, 20 I. & N. Dec. 521, 525-26 (B.I.A. 1992)).

The Eighth Circuit precedent discussed by Judge Raggi is also distinguishable, *see post* at **[19]**, because the case involved state law principles that were established in the context of health insurance and that were found to be inconsistent with FEHBA. *See MedCenters Health Care v. Ochs*, 26 F.3d 865, 866-67 (8th Cir. 1994) (citing *Westendorf v. Stasson*, 330 N.W.2d 699, 703 (Minn. 1983)).

To the extent we should rely on case law interpreting preemption provisions appearing in other statutes, we find *American Airlines, Inc. v. Wolens*, 513 U.S. 219 (1995), more relevant and more instructive. *Wolens* involved the Airline Deregulation Act (ADA), which bars states from "'enact[ing] or enforc[ing] any law relating to [air carrier] rates, routes, or services.'" *Id.* at 221-22 (quoting 49 U.S.C. App. § 1305(a)(1), now codified as amended at 49 U.S.C. 41713(b)). The plaintiffs in *Wolens* were airline customers who brought state law claims for consumer fraud and breach of contract after the airline retroactively took away their frequent flyer miles. The Supreme Court held that the consumer fraud claims, which were brought under a state statute, were preempted, but that the breach of contract action was not. The airline had argued that in passing the ADA, Congress provided that questions of the airline's rights and obligations would be matters of federal and not state law. The Court disagreed, stating:

> [It is not] plausible that Congress meant to channel into federal courts the business of resolving, pursuant to judicially fashioned federal common law, the range of contract claims relating to airline rates, routes, or services. The ADA contains no hint of such a role for the federal courts. In this regard, the ADA contrasts markedly with the ERISA, which does channel civil actions into the federal courts, under a comprehensive scheme detailed in the legislation, designed to promote prompt and fair claims settlement.

Id. at 232 (citation and internal quotation marks omitted).[15]

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[15] Judge Raggi correctly notes that the ADA, unlike ERISA and FEHBA, was aimed at encouraging competition rather than uniformity. *See post* at **[16-17]**. Nevertheless, in distinguishing

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Adopting this same reasoning, we do not believe that FEHBA reveals a congressional objective to resolve all manner of breach of contract suits relating to the Service Benefit Plan in federal court.[16]

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the ADA from ERISA, the *Wolens* court relied heavily on ERISA's civil enforcement scheme. 513 U.S. at 232. If this is the key factor distinguishing the ADA from ERISA, then FEHBA would seem to resemble the former more than the latter.

[16] Judge Raggi cites a House Report stating that the purpose of the 1998 FEHBA amendments was, in part, to "strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts" and to "completely displace State or local law relating to health insurance or plans." H.R. Rep. No. 105-374, at 9, 16 (1997); *see post* at **[11-12]**. Notably, the Report refers to displacing state and local law "*relating to health insurance or plans*," and not to generally applicable state law that may have an effect on benefits or coverage in some cases. *Id.* at 16. (emphasis added). As for the language that relates to bringing claims in federal court, it is something of a mystery what the authors of the report meant by "strengthen the case." This ambiguous wording seems to imply a recognition that the 1998 amendments did not guarantee federal jurisdiction. Given that (1) section 8902(m)(1) is by its plain and unambiguous terms a preemption provision and not a grant of jurisdiction, and (2) the legislative history provides only limited and equivocal support for a contrary conclusion, we do not find that the committee reports cited by Judge Raggi support her broad reading of § 8902(m)(1). *See Padilla v. Rumsfeld*, 352 F.3d 695, 718 (2d Cir. 2003) ("If the plain language is unambiguous, judicial inquiry ends, except in rare and exceptional circumstances, and legislative history is instructive only upon the most extraordinary showing of contrary intentions.") (citation and internal quotation marks omitted), *rev'd on other grounds*, 124 S. Ct. 2711 (2004). The 1998 amendments certainly do expand the preemptive reach of FEHBA, but §

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CONCLUSION

If Congress intended for this case to be heard in federal court, it could have created a private right of action for suits against FEHBA beneficiaries; it could have vested jurisdiction over these claims in the federal courts; or it could have included an affirmative grant of authority to the federal courts to create a body of federal common law. Congress did none of these things.

The preemption provision does not manifest an intent to supplant all state law with federal common law in cases involving FEHBA-authorized contract provisions. Section 8902(m)(1) plainly establishes that only state laws "relat[ing] to health insurance or plans" are subject to preemption. We decline Empire's suggestion that we read this phrase out of the provision. Moreover, even if federal law is likely to preempt McVeigh's defenses and thereby to affect the outcome of the case, this is insufficient to create federal jurisdiction. The well-pleaded complaint rule requires that the complaint itself arise under federal law in order for there to be federal jurisdiction. *See Briarpatch Ltd.*, 373 F.3d at 304. Empire's claims are breach-of-contract claims arising under state law. There is no indication that state law conflicts meaningfully with or is inadequate to achieve the federal interest in this case. Accordingly, we AFFIRM the district court's ruling that Empire's claims arise under state law.

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8902(m)(1) remains a preemption clause, not a grant of federal jurisdiction.

SACK, *Circuit Judge*, concurring:

I concur. I think, for the reasons elaborated by Judge Sotomayor in the principal opinion, that the *Boyle* test is applicable here and that Empire has failed to satisfy the second prong of that test because it has not demonstrated that there is a "significant conflict . . . between an identifiable federal policy or interest and the operation of state law." *Boyle v. United Techs. Corp.*, 487 U.S. 500, 507 (1988) (citation and internal quotation marks omitted). I also agree with Judge Sotomayor's explanation as to why 5 U.S.C. § 8902(m)(1) does not itself authorize the exercise of federal jurisdiction over the cause of action asserted by Empire.

I write separately, though, simply to identify several issues that I think we do not decide.

First, Empire has made a substantial showing that the *first* part of the *Boyle* test has been met because this case implicates "uniquely federal interests," *id.* at 504 (citation and internal quotation marks omitted), in providing uniform healthcare coverage for federal employees and in decreasing the administrative costs associated with such insurance. It may well be that, as in *Boyle*, "the interests of the United States will be directly affected," *id.* at 507, by the outcome of this litigation and of litigation like it. It is Empire's inability to meet the *second*, "significant conflict," part of the test that leads me to join in Judge Sotomayor's opinion affirming the district court's dismissal for lack of subject matter jurisdiction.

Second, a future litigant in a similar action may, unlike Empire here, be able to point to specific ways in which the operation of state contract law, or indeed of other laws of general application, would conflict materially with the federal policies underlying FEHBA in the circumstances presented. In that case, presumably, the second part of the *Boyle* test would be met and, if that litigant's well-pleaded

complaint arises under federal law, a federal court would have subject matter jurisdiction.

Third, there is no need for us to decide what course to take if, "at a later stage in the proceedings, a significant conflict might arise between New York state law and the federal interests underlying FEHBA, such that the dispute would satisfy both prongs of *Boyle*." Opinion of Judge Sotomayor, Part B, ante at **[8]**. This portion of the opinion therefore does not seem to me to set forth a part of our holding on this appeal.

Fourth, and similarly, although I find Judge Sotomayor's discussion in Section C of the principal opinion of the proper reading of section 8902(m)(1) to be both interesting and persuasive, it is not necessary to our resolution of this appeal. It seems to me to be possible, notwithstanding that analysis, that the statute is *unavoidably* unconstitutional because contract terms are not "Laws of the United States," that are "the supreme Law of the Land." *Id.* at **[11]** (quoting U.S. Const. Art. VI, cl. 2). On the other hand, even if the statute does attempt to render contract terms "supreme" despite the fact that they are not strictly "law," perhaps the statute nonetheless would bear constitutional scrutiny. Still, in either case we must affirm because, for reasons spelled out largely in parts A and D of the principal opinion, the district court rightly ruled that it does not have subject matter jurisdiction under either *Boyle* or the statute as written. This discussion in the principal opinion, whatever its merits, therefore seems to me also to be dicta. It is possible that our views would turn out to be otherwise were we to confront a different situation in which this issue actually required our resolution. Should that day come, I do not think that the panel that considers the issue will be bound by our analysis here.

RAGGI, *Circuit Judge*, dissenting:

In this contract action, Plaintiff-Appellant Empire HealthChoice Assurance, Inc., sues Denise McVeigh, as administratrix of Joseph McVeigh's estate, for breach of the reimbursement provision of a federal employee health insurance plan that had covered her husband before his death.[17] The court today rules that this dispute cannot be heard in federal court for lack of subject matter jurisdiction. *See* 28 U.S.C. § 1331. Specifically, it rejects Empire's argument that the case arises under federal common law, concluding that Empire fails to satisfy the "significant conflict" prong of the test established in *Boyle v. United Technologies*, 487 U.S. 500, 507 (1988) (holding that federal courts may create federal common law only where the operation of state law would (1) "significantly conflict" with (2) "uniquely federal interests"). I respectfully disagree. Congress has itself addressed the *Boyle* factors in its 1998 amendment to the preemption provision of the Federal Employees Health Care Protection Act ("FEHBA"), 5 U.S.C. § 8902(m)(1), thereby eliminating the need for courts to consider the question. Section 8902(m)(1) now states: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance of plans." 5

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[17] The statement of benefits for the plan applicable to this case contains the following reimbursement provision: "[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse [the insurer] for benefits . . . paid." 2001 Statement of Benefits, at 86; *see also* 2000 Statement of Benefits, at 45; 1999 Statement of Benefits, at 12; 1998 Statement of Benefits, at 12; 1997 Statement of Benefits, at 12.

U.S.C. § 8902(m)(1). I conclude, for reasons discussed in this dissent, that this language requires courts to construe or enforce any term in a FEHBA plan that relates to health insurance coverage or benefits by reference to uniform federal common law, not state law.

I. Federal Question Jurisdiction

Under 28 U.S.C. § 1331, federal district courts have original jurisdiction of "all civil actions arising under the Constitution, laws, or treaties of the United States." An action "arises under" federal law for purposes of § 1331 jurisdiction only when a plaintiff's well-pleaded complaint alleges a cause of action raising a federal question. *See Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 7 (2003); *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). Such a federal question is presented when the complaint invokes federal law as the basis for relief, *see Merrell Dow Pharm. Inc. v. Thompson*, 478 U.S. 804, 808 (1986); *American Well Works Co. v. Layne & Bowler Co.*, 241 U.S. 257, 260 (1916) (Holmes, J.) (a "suit arises under the law that creates the cause of action"), or when a "substantial, disputed question of federal law is a necessary element of" a well-pleaded state-law claim, *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 13 (1983); *see also Marcus v. AT&T Corp.*, 138 F.3d 46, 56 (2d Cir. 1998).

Empire contends that § 1331 jurisdiction is proper in this case because federal common law governs all disputes involving the enforcement of FEHBA contracts. *See Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972) (holding that § 1331 jurisdiction extends to causes of action governed by federal common law); Woodward Governor Co. v. Curtiss Wright Flight Sys., Inc., 164 F.3d 123, 126 (2d Cir. 1999) (same). Alternatively, Empire argues that even if its claims do arise under state law, they are nevertheless properly heard in federal court because their resolution turns upon an interpretation of the operative Plan, which, Empire submits,

is itself federal law. Because I agree with Empire's first argument, I find it unnecessary to address the second.

II. Federal Common Law

As the majority observes, neither FEHBA nor its regulations expressly provide a federal cause of action for insurance carriers to vindicate their rights under FEHBA contracts. This does not mean that carriers are without a remedy for FEHBA-based disputes. Congress is understood to legislate against the pre-existing backdrop of the common law. *See Astoria Fed. Sav. & Loan Ass'n v. Solimino*, 501 U.S. 104, 108 (1991); *United States v. Nucci*, 346 F.3d 419, 423 (2d Cir. 2004); see also *Kolstad v. American Dental Ass'n*, 527 U.S. 526, 539 (1999) ("[W]here Congress borrows terms of art in which are accumulated the legal tradition and meaning of centuries of practice, it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken and the meaning its use will convey to the judicial mind unless otherwise instructed." (internal quotation marks omitted)). It is an elementary common-law principle that a party to a valid contract is bound by its terms and is subject to suit for their enforcement. *See, e.g., Mobil Oil Exploration & Producing Southeast, Inc. v. United States*, 530 U.S. 604, 607-08 (2000); *Gerrish Corp. v. Universal Underwriters Ins. Co.*, 947 F.2d 1023, 1028 (2d Cir. 1991). *See generally* O.W. Holmes, *The Common Law* 227-40 (1881) (describing the characteristics of contracts). Nothing in FEHBA suggests that FEHBA contracts are to be treated differently. The Act does not, for example, provide a comprehensive remedial scheme that supplants a common-law action, *cf. Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985), nor does it contain an express provision precluding such an action, *see United States v. Nucci*, 364 F.3d at 423. Thus, it is reasonable to conclude that FEHBA contracts are enforceable through common-law

breach of contract actions. *See Jackson Transp. Auth. v. Local Div. 1285, Amalgamated Transit Union*, 457 U.S. 15, 20 (1982) (concluding that although the Urban Mass Transportation Act did not provide a cause of action to enforce contracts entered into pursuant to the Act, "it is reasonable to conclude that Congress expected [these contracts], like ordinary contracts, to be enforceable by private suit upon a breach").

That insurance carriers are able to bring breach of contract actions to vindicate FEHBA rights does not, however, mean that these actions are necessarily federal. The presumption, in fact, is to the contrary. As the Supreme Court declared in *Erie R.R. Co. v. Tompkins*, "there is no federal general common law." 304 U.S. 64, 78 (1938). Thus, contract actions are usually creatures of state law, *see Caceres Agency, Inc. v. Trans World Airways, Inc.*, 594 F.2d 932, 934 (2d Cir. 1979); *see also Aronson v. Quick Point Pencil Co.*, 440 U.S. 257, 262 (1979), and, accordingly, absent diversity in citizenship among the parties, are ordinarily not subject to federal jurisdiction, *see Nolan v. Meyer*, 520 F.2d 1276, 1280 (2d Cir. 1975).

Since issuing *Erie*, however, the Supreme Court has made clear that federal common law displaces state law in certain narrow circumstances. *See Texas Indus., Inc. v. Radcliff Materials, Inc.*, 451 U.S. 630, 640-41 (1981); *see also Hinderlider v. La Plata River & Cherry Creek Ditch Co.*, 304 U.S. 92, 110 (1938) (decided the same day as *Erie* and declaring that "whether the water of an interstate stream must be apportioned between the two States is a question of 'federal common law'"). *See generally* Henry J. Friendly, *In Praise of Erie -- And of the New Federal Common Law*, 39 N.Y.U. L. Rev. 383, 405 (1964) (remarking on the various "specialized" categories of federal common law). Specifically, courts may fashion federal common law (1) when "Congress has given [them] the power" to do so,

Texas Indus., Inc. v. Radcliff Materials, Inc., 451 U.S. at 640-41; or (2) if Congress has not granted such authorization, when (a) a case involves an area of "uniquely federal interests" and (b) the application of state law would "significantly conflict" with federal policies in this area, *Boyle v. United Techs.*, 487 U.S. at 507-08; *accord Woodward Governor Co. v. Curtiss Wright Flight Sys., Inc.*, 164 F.3d at 127; *see also Atherton v. FDIC*, 519 U.S. 213, 218 (1997); *O'Melveny & Myers v. FDIC*, 512 U.S. at 87.

A. Empire's Reliance on *Boyle* to Invoke Federal Common Law

Empire relies on *Boyle v. United Technologies* to support its claim that this contract dispute arises under federal common law. Specifically, it urges this court to follow the Fourth Circuit's application of *Boyle* in *Caudill v. Blue Cross & Blue Shield of North Carolina*, 999 F.2d 74 (4th Cir. 1993). Although I do not think that *Boyle* analysis is necessary to reach this conclusion, I think it useful to begin with a brief discussion of Empire's *Caudill*-based argument.

In *Caudill*, Blue Cross had removed to federal court a state action filed by a FEHBA plan enrollee challenging Blue Cross's denial of benefits.[18] Noting that federal removal

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[18] It is worth noting that at the time Caudill filed his state court action, OPM regulations provided that "litigation to recover on [a FEHBA benefits] claim should be brought against the carrier, not against OPM." 5 C.F.R. § 890.107 (1994). On March 29, 1995, however, OPM amended the regulation to bring virtually all benefit claims by beneficiaries into federal courts: "A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors." 5 C.F.R. § 890.107(c); 60 Fed. Reg. 16,037, 16,039 (March 19, 1995) (interim rule); 61 Fed. Reg. 15,177 (April 5, 1996) (final rule); *see also* 5 U.S.C. § 8912 (providing that "[t]he district courts of the United States have

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jurisdiction is limited to state court actions "of which the district courts of the United States have original jurisdiction," 28 U.S.C. § 1441, the Fourth Circuit ruled that removal was proper because Caudill's claim, although pleaded under state law, actually arose under federal common law. *See Caudill v. Blue Cross & Blue Shield of North Carolina*, 999 F.2d at 77. Applying the *Boyle* standard, the court found that (1) Caudill's claim implicated unique federal interests because, if her suit were successful, it would hinder OPM's ability to enter into future FEHBA contracts and might result in costs being passed through to the federal government, and (2) the use of state law would undermine the federal interest in ensuring that federal employees receive uniform health benefits. *See id.* at 78-79. The latter interest in uniform treatment of enrollees was evinced, the court explained, by FEHBA's preemption provision, which, at that time, stated that "[t]he provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits . . . shall supersede and preempt any State or local law . . . which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions." 5 U.S.C. § 8902(m)(1) (1997).

As the majority notes, *Caudill* has been criticized by courts and commentators. That criticism, however, is not leveled at its conclusion that federal common law governs FEHBA claims, but at its failure to adhere to the well-pleaded complaint rule. *See Goepel v. Nat'l Postal Mail Handlers Union*, 36 F.3d 306, 314-15 (3d Cir. 1994); *see also* 15 James Wm. Moore et al., *Moore's Federal Practice*

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original jurisdiction . . . of a civil action or claim against the United States founded on [FEHBA]").

§ 103.45[3][c] (3d ed. 1997) (commenting that Caudill's holding "is fatally flawed if the validity of the well-pleaded complaint rule . . . [is] accepted"). The criticism is not without force. Under the well-pleaded complaint rule, a plaintiff, as master of his claim, may avoid federal jurisdiction by relying exclusively on state law in his complaint. *See Caterpillar Inc. v. Williams*, 482 U.S. at 392. It appears that Caudill's complaint pleaded claims under only state law, *see Caudill*, 999 F.2d at 77, and, thus, on its face, presented no federal claim justifying removal. Although Blue Cross's contention that federal common law governed Caudill's state claims may have provided the insurer with a federal defense to the claims that it could raise in the state action, this was not a ground for the removal of those state claims to federal court. *See Caterpillar Inc. v. Williams*, 482 U.S. at 393.

Thus it appears that in *Caudill*, removal would have been proper only if Blue Cross had demonstrated that plaintiff's state claims were "completely preempted" by federal law. *City of Rome v. Verizon Communications, Inc.*, 362 F.3d 168, 176-77 (2d Cir. 2004). "[C]omplete preemption" occurs when Congress manifests its intent that federal law displace state law by enacting a "federal statute [that] . . . provide[s] the exclusive cause of action for the claim asserted and also set[s] forth procedures and remedies governing that cause of action"; in such cases, the claim, although pleaded in terms of state law, actually arises under federal law. *Beneficial Nat'l Bank v. Anderson*, 539 U.S. at 8; *City of Rome v. Verizon Communications, Inc.*, 362 F.3d at 177. As the Third Circuit has pointed out, however, FEHBA did not provide a cause of action to vindicate the rights at issue in Caudill's state-law claims. *See Goepel v. Nat'l Postal Mail Handlers Union*, 36 F.3d at 315. Thus, by finding removal proper, the Caudill court implicitly extended the complete preemption doctrine to claims that arise under

federal common law but for which Congress has not manifested an intent to provide an exclusive cause of action. *See id.* at 314-15 (criticizing *Caudill* for expanding the complete preemption doctrine).

In this case, unlike in *Caudill*, the propriety of applying federal common law does not depend on complete preemption. Empire's complaint does not plead claims in terms of state law; rather, it relies exclusively upon federal law. Thus, this court need not decide whether a state-law claim to enforce the terms of a FEHBA plan may be recharacterized as arising under federal law. It need decide only whether federal common law does in fact govern claims to enforce rights under a FEHBA plan. If it does, then this case arises under federal law and the district court had jurisdiction to hear it.

I conclude that federal common law does govern the parties' dispute in this case, but I do not rely on *Boyle*. Instead, I conclude that in amending § 8902(m)(1) in 1998, Congress itself addressed the *Boyle* factors, making the analysis undertaken in *Caudill* unnecessary. The amendment necessarily grants courts the power to develop uniform federal common law to construe and enforce the coverage and benefit terms of FEHBA plans.

B. Congressional Authorization in § 8902(m)(1) for Federal Common Law to Construe and Enforce FEHBA Plans

In 1998, Congress amended FEHBA's preemption provision by striking the clause alluded to in *Caudill*, providing for preemption of state laws only "to the extent [they are] inconsistent with" a contractual term, see Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998), and enacting a more expansive provision that reads in full: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including

payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1).

The amendment thus effectively legislates both *Boyle* factors. First, by providing for FEHBA coverage and benefits terms to "supersede" certain state and local laws, Congress has identified a unique federal interest in ensuring national uniformity in the construction and enforcement of such terms. Second, by amending § 8902(m)(1) to eliminate the need for any judicial finding of conflict between contract terms and certain state and local laws, Congress has implicitly authorized courts to employ federal common law to resolve disputes concerning coverage and benefits, even in the absence of the conflict generally required by *Boyle*.

As the majority observes, a literal reading of § 8902(m)(1) could give rise to constitutional concerns. The Supremacy Clause makes plain that the terms of a federal contract cannot by themselves preempt state law; only federal law can preempt state law. *See* U.S. Const. Art. VI, cl. 2. Because courts assume that Congress legislates in light of constitutional limitations, *see Rust v. Sullivan*, 500 U.S. 173, 191 (1991), however, it is reasonable to conclude that the operation of federal law is necessarily implicit in § 8902(m)(1), *see generally Edward J. Bartolo Corp. v. Florida Gulf Coast Bldg. Constr. Trades Council*, 485 U.S. 568, 575 (1988) (noting that where "an otherwise acceptable construction" of a statute is available that is not "plainly contrary to the intent of Congress," courts may adopt that construction to avoid serious constitutional doubts); *accord Jones v. United States*, 526 U.S. 227, 239-40 (1999). Mindful of this principle, I read § 8902(m)(1) to mean that any terms in a FEHBA plan that relate to coverage or benefits are to be construed according to uniform federal

law, and that *law* will, in turn, supersede any state or local law that relates to health insurance or health plans.

My colleagues in the majority apparently agree that the application of federal law is implicit in § 8902(m)(1)'s preemption of certain state laws. Where we disagree is in our assessment of whether that preemption is limited to laws specifically addressing "health insurance or plans," or whether it also extends to general state and local law, including contract law, when an action is brought to construe and enforce a coverage or benefits term in a FEHBA health insurance plan. I conclude that such actions necessarily arise under federal common law because § 8902(m)(1) precludes any state law, including contract law, from construing or enforcing the coverage or benefit terms of FEHBA plans. When the application of state contract law would have that effect, the law "relates to health insurance or plans."

Unlike its predecessor, which limited preemption to state laws that actually *conflicted* with the terms of a FEHBA contract, the 1998 amendment to § 8902(m)(1) precludes state laws that relate to health insurance or plans from playing any role in construing such coverage or benefits terms. *See Botsford v. Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *see also Russello v. United States*, 464 U.S. 16, 23-24 (1983) (when Congress deletes limiting language, "it may be presumed that the limitation was not intended"). While this amendment, on its face, indicates Congress's intent significantly to expand § 8902(m)(1) preemption, a House Report confirms the breadth of the new provision, explaining that the amendment was intended "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they live" and to "strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." by "completely displac[ing] State or local law relating to health insurance or plans." H.R. Rep. No. 105-

374, at 9, 16 (1997); *see also* S. Rep. No. 105-257, at 15 (1997) (amendment "removes the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority").

Although FEHBA does not define what it means for a state or local law to "relate[] to health insurance or plans," the Supreme Court has, in other contexts, recognized that the common meaning of the phrase "relate to" is expansive: "'to stand in some relation; to have bearing or concern, to pertain; refer; to bring into association with or connection with.'" *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) (quoting BLACK'S LAW DICTIONARY 1158 (5th ed. 1979)) (discussing the phrase "relating to" in the context of the Airline Deregulation Act of 1978). Our court has also concluded that the phrase does not imply a causal connection; rather, it is synonymous with the phrases "in connection with," "associated with," "with respect to," and "with reference to." *Coregis Ins. Co. v. American Health Found.*, Inc., 241 F.3d 123, 128-29 (2d Cir. 2001) (interpreting insurance contract); *accord Kamagate v. Ashcroft*, 385 F.3d 144, 154 (2d Cir. 2004) (applying broad definition to removal statute); *see Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (applying same definition in ERISA context); *see also Celotex Corp. v. Edwards*, 514 U.S. 300, 308 n.5 (1995) (stating that proceedings "related to" a bankruptcy include "suits between third parties which have an effect on the bankruptcy estate").

In the ERISA context, the Supreme Court has ruled that "[u]nder this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987)). Recognizing the potential all-encompassing breadth of this definition, the

Court has increasingly focused on ERISA's objective to establish a uniform system of benefits in determining whether a particular state law "relates to" a plan. In light of this federal interest in uniformity, the Court has concluded that a state law of general application "relates to" an ERISA plan where application of the different states' laws could yield inconsistent benefit outcomes in similar cases. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) ("[L]aws providing alternative enforcement mechanisms also relate to ERISA plans . . . ."); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139. Following these decisions, our court has concluded that ERISA preempts generally applicable state contract law when that law is relied upon to enforce a benefits plan. *See Devlin v. Transp. Communications Int'l Union*, 173 F.3d 94, 101 (2d Cir. 1999).

This precedent supports the conclusion that FEHBA preemption is not limited to state and local laws that expressly regulate health insurance or plans.[19] Nor is it limited to specialized state rules applicable only to insurance plans, for example, a rule of decision providing for ambiguities in an insurance policy to be resolved in favor of the insured. *See, e.g., City of Burlington v. Indemnity Ins. Co. of N. Am.*, 332 F.3d 38, 45 (2d 9 Cir. 2003); *Mostow v. State Farm Ins. Cos.*, 88 N.Y.2d 321, 326, 645 N.Y.S.2d

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[19] Where Congress has intended to limit preemption to laws specifically regulating particular conduct, it has so indicated. *See, e.g.*, 7 U.S.C. § 27f(c) (limiting preemption to state laws that "prohibit[ ] or regulate[ ] gaming or the operation of bucket shops" in certain contexts); 8 U.S.C. § 1188(h)(2) (limiting preemption to state or local laws "regulating admissibility of nonimmigrant workers").

421, 423 (1996). Rather, FEHBA preemption also extends to general laws that can reasonably be understood to "relate to health . . . plans" whenever such laws would attempt to construe or enforce the coverage or benefits terms of FEHBA health plans.

The majority concludes that ERISA precedent is not helpful in determining the preemptive reach of § 8902(m)(1). Certainly, ERISA is a more comprehensive remedial statute than FEHBA, but that does not warrant a different conclusion with respect to preemption. The statutes' preemption clauses are notably similar. ERISA preemption applies to "any and all State laws insofar as they may now or hereafter *relate to any employee benefit plan* described in [the statute]." 29 U.S.C. § 1144(a) (emphasis added). FEHBA preemption applies to "any State or local law, or any regulation issued thereunder, *which relates to health insurance or plans*." 5 U.S.C. § 8902(m)(1) (emphasis added). More important, the objectives of the two laws are virtually identical. FEHBA -- in particular, its amended preemption provision -- is designed "to offer uniform benefits" to tens of thousands of federal employees across the nation. H.R. Rep. No. 105-374, at 9.

The majority suggests that construing § 8902(m)(1) to apply to state contract law renders meaningless the statute's limitation of federal preemption to state or local law that "relates to health insurance or plans." I cannot agree. Here again, ERISA precedent is instructive in distinguishing between generally applicable state laws that "relate to" health plans and laws that tangentially implicate such plans without relating to them. For example, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 841 (1988), the Supreme Court concluded that ERISA preemption of state laws that "relate to any employee benefit plan" did not extend to a state's garnishment statute, even though the garnishment would operate on ERISA benefits. In that case,

state law did not attempt to construe the benefits afforded under an ERISA plan; it merely authorized the garnishment of whatever benefits were payable thereunder. Similarly, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at 660-61, the Court noted that generally applicable state quality control and workplace regulations may tangentially affect what benefits an ERISA plan will be able to afford, but they do not attempt to construe the benefits provided by any particular plan. Application of these decisions to this case suggests that where a state law of general application would be employed to construe the rights enforceable under the coverage or benefits terms of a FEHBA plan, such a law "relates to health insurance or plans" and is properly preempted by federal law. But where general state or local law affects FEHBA coverage or benefits only tangentially, without attempting to construe or enforce those plan terms, preemption may not be warranted. Put another way, § 8902(m)(1) contemplates that the coverage and benefits terms of FEHBA plans will always be construed only by reference to uniform federal common law. That law will then preempt any state or local laws that relate to health insurance or plans, both (1) laws specifically denominated as such and (2) general laws that are fairly deemed to "relate[] to health insurance or plans" in those cases where such laws would attempt to construe the coverage or benefits terms of such a plan.

American Airlines, Inc. v. Wolens, 513 U.S. 219 (1995), is not to the contrary. The question in that case was whether the Airline Deregulation Act's preemption clause, which forbids states from enacting or enforcing "any law . . . relating to [air carrier] rates, routes, or services," 49 U.S.C. App. § 1305(a)(1) (1993) (now codified with technical changes at 49 U.S.C. § 41713), preempts a state law contract action to enforce rates, routes, and services set forth in an agreement

between private parties. The Supreme Court said the answer was no. *Wolens*, 513 U.S. at 228-29. It explained that the Deregulation Act preempted only state-imposed, as opposed to privately contracted-for, rates, routes, and services. Moreover, the purpose of the Deregulation Act was to encourage competition in these areas, which anticipated a variety of private contractual arrangements. In this context, the Court observed that it was not "plausible that Congress meant to channel into federal courts the business of resolving, pursuant to judicially fashioned federal common law, the range of contract claims relating to airline rates, routes, or services." *Id.* at 232. In so ruling, the Court specifically distinguished the Deregulation Act from ERISA. *See id.* (noting that ERISA "does channel civil actions into federal court . . . under a comprehensive scheme . . . to promote prompt and fair claims settlement" (internal citations omitted)). Precisely because ERISA's objective is uniformity rather than competition, it makes sense to conclude that Congress intended contract claims arising under that statute to be reviewed according to a single national legal standard.

The same conclusion obtains as to FEHBA. The 1995 amendment to 5 C.F.R. § 890.107 channels the vast majority of benefits claims -- those by plan beneficiaries -- into federal court. *See* 5 C.F.R. § 890.107(c). As for any remaining FEHBA actions, Congress's expectation when it amended 5 U.S.C. § 8902(m)(1) in 1998 was to "strengthen the case for trying FEHB program disputes in Federal courts rather than state courts." H.R. Rep. No. 105-374, at 9, 16. Further, as already discussed, FEHBA's preemption provision and its uniformity objective have more in common with ERISA than with the Deregulation Act in signaling Congress's intent to have the coverage and benefits terms of FEHBA health insurance plans construed according to uniform federal common law. FEHBA does not simply bar

states from enacting laws with respect to the coverage and benefit terms of federal health plans. It contemplates that the coverage and benefits terms of FEHBA plans will themselves supersede any state laws that relate to health insurance or health plans, something possible under the Supremacy Clause only if the construction and enforcement of those plan terms are the exclusive province of federal common law.

I recognize that in *Wolens* the Supreme Court observed that "contract law is not at its core 'diverse, nonuniform, and confusing.'" 513 U.S. at 233 n.8 (quoting *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 529 (1992) (plurality opinion)). Thus, the Court anticipated no serious risk of nonuniform adjudication in the enforcement of a nationwide contract by the various states. The amendment to § 8902(m)(1), however, makes plain that Congress was not limiting FEHBA preemption to state laws that might conflict with the terms of federal-employee health plans. Rather, Congress has made clear that it deems any state laws relating to health insurance or health plans, even those that are consistent with federal law, as an obstacle to the uniform construction and enforcement of FEHBA plans. *Cf. Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 139 ("Preemption is also not precluded simply because a state law is consistent with ERISA's substantive requirements.").

Here, Empire seeks to enforce a FEHBA plan term that expressly conditions the receipt of benefits on an enrollee's duty to reimburse the insurer if he recovers in tort from the third party causing his injuries. Because the operative Plan's reimbursement requirement plainly "relates to" the provision of insurance benefits, I conclude that under the broad preemption provision of § 8902(m)(1), Empire cannot look to state contract law to construe or enforce its rights. *See Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 926 (9th Cir. 1987) (holding that state law contract and tort claims,

which expanded obligations under the terms of a FEHBA plan, were preempted under the earlier version of § 8902(m)(1)). In that context, state contract law qualifies as a law that "relates to health insurance or plans," which is necessarily preempted by federal common law construing FEHBA coverage and benefits terms.

The 1998 amendment to § 8902(m)(1) was surely not designed to expand federal preemption of state law in order to leave insurance carriers without any means to enforce their rights under FEHBA plans. For reasons already discussed, I assume that Congress intended FEHBA contracts to be enforceable. *See Jackson Transp. Auth. v. Local Div. 1285, Amalgamated Transit Union*, 457 U.S. at 20. Because I conclude that Congress expressly proscribed the use of state contract law to construe rights relating to FEHBA benefits or coverage, it logically follows that Congress was thereby authorizing courts to look to federal common law both to construe those rights uniformly and to resolve insurance carriers' FEHBA claims. *See, e.g., Itar-Tass Russian News Agency v. Russian Kurier, Inc.*, 153 F.3d 82, 90 (2d Cir. 1998) (stating that when a statute recognizes rights but fails to provide necessary principles for their enforcement, courts must "fill the interstices of the Act by developing federal common law").

This conclusion is consistent with *MedCenters Health Care v. Ochs*, 26 F.3d 865, 867 (8th Cir. 1994). Relying on the pre-1998 preemption provision of FEHBA, the Eighth Circuit rejected a jurisdictional challenge to a FEHBA carrier's contract claim for restitution, holding that federal law governs such claims. Although the decision is brief, I can only assume that its respected author, Judge Richard Arnold, thought it so obvious that Congress had authorized federal common law to resolve FEHBA coverage or benefits disputes that the point merited little discussion. *See also Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572 (11th Cir.

1985) (citing FEHBA's former preemption provision for proposition that federal law controls interpretation of FEHBA contracts). *Cf. Goepel v. Nat'l Postal Mail Handlers Union*, 36 F.3d at 309 n.3, 315 (recognizing that FEHBA claims may be governed by federal common law, but declining to reach the issue).

In sum, because (1) Empire's contract action seeks to enforce the benefits terms of a FEHBA plan; (2) § 8902(m)(1) contemplates that such benefits terms will uniformly be construed and enforced according to federal common law; and (3) any state law, including contract law, invoked to construe and enforce such benefits terms qualifies as a law that "relates to health insurance or plans" preempted by federal common law, I conclude that Empire's action is a case arising under federal common law over which the district court could properly exercise jurisdiction.

C. The Effect of 5 U.S.C. § 8912 on Federal Jurisdiction in this Case

Ms. McVeigh insists that, even if Empire's claims arise under federal common law, the district court cannot exercise § 1331 jurisdiction over them because federal jurisdiction over FEHBA claims is limited to that expressly conferred in 5 U.S.C. § 8912 (vesting federal courts with "original jurisdiction . . . of a civil action or claim against the United States founded on" FEHBA). Because the majority concludes that Empire's claims do not arise under federal common law, it does not reach this issue. Because I reach a different conclusion with respect to the application of federal common law, I write briefly to explain why I reject Ms. McVeigh's § 8912 argument.

Absent some indication to the contrary, statutes vesting courts with jurisdiction over certain matters do not strip courts of their jurisdiction over others. As the Supreme Court stated in *Verizon Maryland, Inc. v. Public Service Commission of Maryland*, "[t]he mere fact that some acts are

made reviewable [under a statute] should not suffice to support an implication of exclusion as to others." 535 U.S. 635, 643-44 (2002) (internal quotation marks omitted). Section 8912 does not purport to deprive federal courts of § 1331 jurisdiction. It simply authorizes federal jurisdiction over FEHBA claims against the United States. *See Rice v. Office of Servicemembers' Group Life Ins.*, 260 F.3d 1240, 1244-46 (10th Cir. 2001) (holding that 38 U.S.C. § 1975, which grants district courts "original jurisdiction of any civil action or claim against the United States founded upon [the Servicemen's Group Life Insurance Act (SGLIA)]," does not preclude § 1331 jurisdiction of SGLIA suits against parties other than the United States). Indeed, without the provision, sovereign immunity would bar such claims. *See Adeleke v. United States*, 355 F.3d 144, 150 (2d Cir. 2004). But nothing in § 8912 evinces Congress's intent to limit § 1331's jurisdictional grant in FEHBA cases involving parties other than the United States.

For all these reasons, I conclude that this suit to enforce the terms of a FEHBA plan does arise under federal common law, and I dissent from the majority's conclusion that the case was properly dismissed for lack of subject matter jurisdiction.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

August Term, 2004

[Petition for rehearing filed: January 28, 2005]

[Decided: March 16, 2005]

Docket No. 03-9098

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross and Blue Shield,

Plaintiff-Appellant,

v.

DENISE FINN MCVEIGH, as administratrix of the Estate of Joseph E. McVeigh,

Defendant-Appellee.

Before: SACK, SOTOMAYOR and RAGGI, *Circuit Judges*.

ON PETITION FOR REHEARING BY THE PANEL

SOTOMAYOR, *Circuit Judge*:

Appellant Empire HealthChoice Assurance, Inc. ("Empire") petitions the panel for rehearing to reconsider its decision in *Empire HealthChoice Assurance, Inc. v.*

McVeigh, 396 F.3d 136 (2d Cir. 2005). The Association of Federal Health Organizations ("AFHO") and the United States have each submitted briefs as amicus curiae in support of Empire's petition. We assume familiarity with our original decision and its underlying facts. Because Empire and its amici have failed to demonstrate "point[s] of law or fact that . . . the court has overlooked or misapprehended," the petition is denied. Fed. R. App. P. 40(a); *see Treadway Cos., Inc. v. Care Corp.*, 638 F.2d 357, 386 (2d Cir. 1980).

Empire contends that our original decision improperly disregarded the principle "that suits to determine the rights of the United States under its contracts are governed by federal common law." Appellant's Petition for Rehearing and Rehearing En Banc at 8. This argument misses the point, however, because Empire has not brought suit to determine the rights of the United States. Rather, Empire seeks to vindicate its own rights against another private party. This distinguishes the instant case from the precedents cited by Empire, which involved suits to which the United States was itself a party.[1] *See United States v. Seckinger*, 397 U.S. 203 (1970); *United States v. County of Allegheny*, 322 U.S. 174 (1944), *abrogated on other grounds by United States v. City of Detroit*, 355 U.S. 466 (1958); *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943); *Up State Fed. Credit Union v. Walker*, 198 F.3d 372 (2d Cir. 1999).[2] A monetary

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[1] For substantially the same reasons, we reject the AFHO brief's suggestion that Empire has brought suit "to vindicate [the] rights . . . of the federal government." Brief of the Association of Federal Health Organizations at 6.

[2] Empire also relies on *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988). Our previously issued opinion, however, already provides a comprehensive explanation of why *Boyle* does not establish that we have jurisdiction over Empire's claims.

recovery by Empire might benefit the United States, but this is insufficient to require displacement of state law. *See Boyle v. United Techs. Corp*, 487 U.S. 500, 507 (1988); *Empire*, 396 F.3d at 140-42.[3]

Building on Empire's argument, the government argues that "suits to enforce contracts 'contemplated by federal statutes'" such as the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914, state a federal claim if "Congress intended that the contracts be 'creations of federal law' and that 'the rights and duties contained in those contracts be federal in nature.'" Brief of the United States at 8-9 (quoting *Jackson Trans. Auth. v. Local Div. 1285*, 457 U.S. 15, 22-23 (1982)). In *Jackson Transit*, the Supreme Court held that "suits to enforce contracts contemplated by federal statutes *may* set forth federal claims," and that "private parties *in appropriate cases* may sue in federal court to enforce contractual rights created by federal statutes." 457 U.S. at 22 (emphasis added). The "critical factor" in determining "the scope of rights and remedies under a federal statute," the Court held, was "congressional intent." *Id.* at 22-23. In the instant case, the "critical factor" of congressional intent is embodied in FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1), which addresses the extent to which federal law will govern FEHBA-related claims.

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[3] In an attempt to remedy its earlier failure to satisfy the "conflict" prong of *Boyle*, Empire's petition for rehearing cites to a responsive pleading filed by McVeigh in the district court that had relied on a New York State statute of limitations. Empire did not raise this argument in its briefs on appeal, however, and we therefore will not consider it. *See Anderson v. Branen*, 27 F.3d 29, 30 (2d Cir. 1994) (per curiam). In any event, the argument could not have made a difference under the original opinion's analysis, as Empire concedes.

For reasons explained in Part D of the panel's original majority opinion, *see Empire*, 396 F.3d at 145-49, that preemption provision, while broad, does not confer federal jurisdiction over Empire's claims. *See also Miree v. DeKalb County*, 433 U.S. 25, 26-30 (1977) (holding that state law, rather than federal common law, controlled a dispute where "only the rights of private litigants [were] at issue," even though the dispute required interpretation of a federal contract and implicated federal operations "of considerable magnitude").[4]

Misconstruing Part C of our principal opinion, Empire takes particular issue with what it regards as the panel's conclusion that § 8902(m)(1) is unconstitutional. We held no such thing. Instead, we interpreted the provision so as to *avoid* declaring it unconstitutional. Moreover, our discussion of the constitutional difficulties inherent in a literal reading of § 8902(m)(1) was not an essential component of our holding that § 8902(m)(1) does not authorize jurisdiction. Even if a literal reading posed no constitutional concern, our analysis in part D of the principal opinion makes clear that the provision does not create

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[4] The government also argues that federal jurisdiction exists because federal law is a "necessary element" of the claim for relief. Brief of the United States at 2-3. In so arguing, the government relies on *Christianson v. Colt Industries Operating Group*, 486 U.S. 800 (1988), which simply reiterated the principle that federal jurisdiction "extends over only those cases in which a well-pleaded complaint establishes either that federal law creates the cause of action or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." *Id.* at 808 (citation and internal quotation marks omitted). For reasons explained in this opinion as well as in our original opinion, Empire's claim does not satisfy this test.

jurisdiction here. Reconsideration of the constitutional issue therefore could not affect the outcome of the case.[5]

Finally, we note our disagreement with the conclusions reached in *Blue Cross and Blue Shield of Illinois v. Cruz*, 396 F.3d 793 (7th Cir. 2005), which the Seventh Circuit decided ten days after we issued our original decision in *Empire*. The *Cruz* court rested its holding on arguments that we addressed and squarely rejected in our original opinion.

We have considered the remaining arguments set forth by Empire and its amici and find them to be without merit. By emphasizing such factors as the potential practical effects of our original holding on the administration of FEHBA programs, Empire and its amici present, at most, cogent arguments for why, as a policy matter, federal jurisdiction should be extended to cover Empire's claims. Such policy arguments, however, are for Congress rather than the courts to consider, for it is well-established that federal courts will not assume jurisdiction over contract disputes "in the absence of an unambiguous expression of congressional intent." *Jackson Transit*, 457 U.S. at 30 (Powell, J., joined by O'Connor, J., concurring); *see also id.* ("By enforcing contract rights not within the jurisdictional grant conferred by Congress, as much as by improperly inferring a right of action, a court of limited jurisdiction necessarily extends its authority to embrace a dispute Congress has not assigned it to resolve. . . . This runs contrary to the established principle that [t]he jurisdiction of the federal courts is carefully guarded against expansion by judicial interpretation . . . ." (alterations in original) (citation and internal quotation marks

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[5] For similar reasons, contrary to Empire's contention, 28 U.S.C. § 2403 imposed no obligation to allow intervention by the government.

omitted)). The instant case provides no reason to depart from these principles.

For the reasons discussed, the petition for rehearing is DENIED.

Judge Raggi votes to grant rehearing for the reasons stated in her original dissent.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT
Thurgood Marshall U.S. Court House
40 Foley Square
New York 10007

Roseann B. MacKechnie
CLERK

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, Foley Square, in the City of New York, on the 10th day of May two thousand five.

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross And Blue Shield,

Plaintiff-Appellant,

v. 03-9098

DENISE FINN MCVEIGH, as administratrix of the Estate of Joseph E. McVeigh,

Defendant-Appellee.

A petition for panel rehearing and a petition for rehearing en banc having been filed herein by the appellant Empire Healthchoice. Upon consideration by the panel that decided the appeal, it is Ordered that said petition for rehearing is **DENIED**.

It is further noted that the petition for rehearing en banc has been transmitted to the judges for the court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

For the Court,

Roseann B. MacKechnie, Clerk

By: /s/

Motion Staff Attorney

APPENDIX D

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE
d/b/a Empire Blue Cross and Blue Shield,

Plaintiff,

v.

DENISE FINN MCVEIGH, as administratrix of the Estate of Joseph E. McVeigh,

Defendant.

OPINION & ORDER
(03 Civ. 2728 (DLC)

DENISE COTE, *District Judge*

This case raises the issue of whether there is federal subject matter jurisdiction over a contract suit filed by the administrator of a federal employee health benefits plan against a beneficiary. Plaintiff Empire HealthChoice Assurance, or Empire Blue Cross Blue Shield ("Empire"), underwrites and administers a health benefits plan for federal employees and their dependents. It has brought suit to obtain reimbursement for benefits that it paid on behalf of one of its

beneficiaries to cover medical care he received following his injury in an accident. It claims an entitlement to money paid to the beneficiary's estate to settle a lawsuit over the accident brought on behalf of the beneficiary. For the following reasons, the defendant's motion to dismiss for lack of subject matter jurisdiction is granted.

Pursuant to the Federal Employees Health Benefit Act, 5 U.S.C. § 8901 *et seq.* ("FEHBA"), the United States Office of Personnel Management ("OPM") is responsible for establishing and regulating federal health benefits plans. OPM entered a contract with the Blue Cross Blue Shield Association ("BCBSA") to create a Service Benefit Plan for federal employees. Empire is the entity that administers the BCBSA Service Benefit Plan in New York ("Plan").

Defendant Denise Finn McVeigh ("McVeigh") is the administratrix of the estate of Joseph E. McVeigh ("Estate"). Joseph E. McVeigh ("Decedent") had been enrolled in the Empire Plan. In 1997, the Decedent suffered injuries in an accident. Empire paid $157,309.06 in benefits for Decedent's medical treatment between 1997 and 2001, the year of his death. McVeigh filed a tort action in state court on her own behalf and on Decedent's behalf against the third parties who allegedly had caused Decedent's injuries. A suit on behalf of the McVeigh's minor child also was filed in state court. In March 2003, the litigants entered a stipulation settling the lawsuits for a total of $3,175,000.

Before the settlement had been entered, Empire became aware that McVeigh had reached an agreement with the defendants in the state court action. Empire notified McVeigh's counsel that it had a lien on the Estate's share of the settlement for $157,309.06, the amount paid out in benefits under Empire's Plan. McVeigh disputed the existence of the lien. Since the dispute between Empire and McVeigh had not been resolved at the time the stipulation was entered, McVeigh agreed to place $100,000 of the

Estate's portion of the settlement funds in escrow pending resolution of Empire's claims. Empire agreed that it would assert its claim by filing suit within thirty days of the March 19, 2003 settlement hearing. This is that lawsuit.

Empire's claim to $157,309.06 from the McVeigh Estate arises from the Plan. The Plan contains subrogation and right-of-recovery provisions which entitle the local BCBSA administrator to reimbursement if the Plan participant recovers compensation from a third party for injuries suffered for which the administrator paid benefits. The Plan provides that "the Plan is subrogated to [the participant] and [his] dependent's present and future claims against a third party." It also provides that "All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid." It provides that the Plan will have a lien on recoveries obtained from third parties, and that participants are required to notify the Plan of any recovery from third parties and "to reimburse the Plan to the extent of benefits paid by the Plan."

Empire asserts two causes of action. First, Empire claims McVeigh breached the terms of the Plan by refusing to reimburse Empire the amount Decedent received in benefits, and by rejecting Empire's assertion of a lien. Second, Empire seeks a judgment declaring that pursuant to the Plan, FEHBA and its regulations, and federal common law, it is entitled to reimbursement from McVeigh for the amount of benefits paid. The complaint does not assert diversity jurisdiction. McVeigh moves to dismiss for lack of subject matter jurisdiction, for failure to state a claim, and on the ground that the action is time-barred by the statute of limitations; in the alternative, she moves for summary judgment.

Discussion

Empire claims that federal jurisdiction over this action exists because resolution of the claims will require

construction of FEHBA and the regulations and contracts promulgated thereunder and because the action implicates federal common law. Neither argument is compelling, and each is addressed below.

Pursuant to Section 1331 of Title 28 of the United States Code ("Section 1331"), federal courts have jurisdiction over actions "arising under the Constitution, laws, or treaties of the United States." *Id.* Federal question jurisdiction is "limited," and "must be determined by reference to the well-pleaded complaint." *Merrell Dow Pharm. v. Thompson*, 478 U.S. 804, 807-08 (1986) (citation omitted). The "vast majority" of the cases in which there is federal question jurisdiction are cases in which "federal law creates the cause of action," *id.* at 808 (citation omitted), although there may also be jurisdiction where resolution of a claim necessarily turns on construction of federal law. *Id.* The fact that a court must interpret federal law or federal regulations to determine the merits of the action is not ordinarily sufficient, however, to confer federal jurisdiction. *Id.* at 813-14. Any other rule would undercut the Congressional determination not to create a private right of action. *Id.* at 812. Therefore, "where state law creates the cause of action, we ask whether that cause of action poses a substantial federal question." *D'Alessio v. New York Stock Exchange*, 258 F.3d 93, 99 (2d Cir. 2001) (citation omitted).

If federal common law governs a case, there is subject matter jurisdiction just as there is when a federal statute governs the case. *See Woodward Governor Co. v. Curtiss-Wright Flight Sys., Inc.*, 164 F.3d 123, 126 (2d Cir. 1999) (citing *Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972)). There is, however, "no federal *general* common law." *Id.* (citing *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 78 (1938)) (emphasis supplied by *Woodward*). Instead, federal common law applies only to the few cases raising "uniquely federal interests." *Boyle v. United Tech. Corp.*, 487 U.S.

500, 504 (citation omitted); *see also Woodward Governor Co.*, 164 F.3d at 126-27. Such interests arise only in limited areas, such as "(1) the obligations to, and rights of, the United States under its contracts; (2) the liability of federal officers for official acts; and (3) civil liabilities arising out of federal procurement contracts relating to national defense." *Woodward Governor Co.*, 164 F.3d at 127 (citing *Boyle*, 487 U.S. at 504-06)).

A federal common law rule of decision will not be created unless "there is a significant conflict between some federal policy or interest and the use of state law." *O'Melveny & Myers v. FDIC*, 512 U.S. 79, 87 (1994) (citation omitted). "[A]n actual, significant conflict between a federal interest and state law must be 'specifically shown,' and not generally alleged." *Woodward Governor Co.*, 164 F.3d at 127 (quoting *Atherton v. FDIC*, 519 U.S. 213, 214 (1997)). Without a significant conflict, "a mere federal interest in uniformity is insufficient to justify displacing state law in favor of a federal common law rule." *B.F. Goodrich v. Betkowski*, 112 F.3d 88, 90 (2d Cir. 1997) (*per curiam*).

The FEHBA does not purport to create a private cause of action under federal law. It provides only that "[t]he district courts of the United States have original jurisdiction . . . of a civil action or claim *against the United States* founded on this chapter." 5 U.S.C. § 8912 (emphasis supplied). Nor does FEHBA completely preempt relevant state or local law relating to health insurance or plans. The FEHBA preemption provision provides only that

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans *to the*

> *extent that such law or regulation is inconsistent with such contractual provisions.*

5 U.S.C. § 8902m(l) (emphasis supplied).

The FEHBA gives OPM authority to contract with qualified carriers, 5 U.S.C. § 8902(a), but does not dictate the terms of the contracts. For example, the statute requires that each contract entered pursuant to FEHBA shall include a statement of benefits, *id.* at § 8902(d), but does not set forth the specific benefits or provisions to be included in each contract. It provides, *inter alia*, that "the [OPM] may prescribe reasonable minimum standards for health benefits plans . . . and for carriers offering the plans," *id.* at § 8902(e), but does not define those standards. Sections 8903 and 8903a of FEHBA set forth the types of health benefits plans the OPM may contract for, but they do not set forth detailed provisions to be included in each contract. *See id.* at §§ 8903(1)-(4) & 8903a(a)-(d). Similarly, Section 8904 sets forth the types of benefits to be provided under the various plan types, but does not detail the provisions to be included in each statement of benefits. *See id.* at § 8904 (1) - (4).

Empire's claims for breach of contract and for declaratory judgment require determinations regarding the respective rights and obligations of two private parties to the health insurance contract at issue.[1] This is insufficient to create federal jurisdiction. Instead of alleging the "uniquely federal interest" required to establish federal jurisdiction arising under federal common law, *Boyle*, 487 U.S. at 504, the only federal interest Empire identifies is the potential recovery by the United States Treasury of any reimbursement paid by the

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[1] Empire does not argue that it is anything but a private entity, and does not attempt to invoke Section 8912 of FEHBA, which creates federal jurisdiction over claims arising under the statute against the United States.

McVeigh estate to Empire. In addition, Empire has not identified "an actual, significant conflict" between state law and any federal interest. *Woodward Governor Co.*, 164 F.3d at 127. Instead, Empire suggests that the mere act of applying state law will create a conflict because it will undermine the federal interest in uniformity. As the Second Circuit has made clear, however, an interest in uniformity is insufficient by itself to give rise to federal jurisdiction. *See B.F. Goodrich v. Betkowski*, 112 F.3d 88, 91 (2d Cir. 1997) (*per curiam*).

Empire's alternative argument that the Statement of Benefits is itself "federal law," and equivalent to a federal regulation, is similarly unavailing. Even the mandatory incorporation of federal standards into a contract does not transform that contract into a regulation, nor create federal jurisdiction over an action for breach of the contract. *See Jackson Transit Auth. v. Local Div. 1285, Amalgamated Transit Union, AFL-CFO-CLC*, 457 U.S. 15, 22-23 (1982); *J.A. Jones Constr. Co. v. City of New York*, 753 F. Supp. 497, 501 (S.D.N.Y. 1990). "Because a federal court should exercise extreme caution before assuming jurisdiction not clearly conferred by Congress, we should not condone the implication of federal jurisdiction over contract claims in the absence of unambiguous expression of congressional intent." *Jackson Transit.*, 457 U.S. at 30 (Powell, J., concurring).

Empire relies heavily on the Second Circuit's decision in *Marcus v. AT&T Corp*, 138 F.3d 46 (2d Cir. 1998), in which the court held that federal jurisdiction existed over an action for breach of the warranties contained in certain tariffs required by the Federal Communications Act to be filed with the Federal Communications Commission. *Id.* at 56. The tariffs "*conclusively and exclusively* enumerate the rights and liabilities of the contracting parties," and are the governing "law." *Id.* (citation omitted) (emphasis in original). Although the Plan was established pursuant to the OPM's

obligations under FEHBA, no federal statute or regulatory scheme sets out the terms of the Plan, or the rights and obligations of its participants, and the Plan is not filed with or enforced by any regulatory agency. OPM's authority under federal law to contract for health benefits plans does not convert the terms of the plans themselves into federal law or otherwise confer federal jurisdiction over an action for breach of a plan's provisions. *See Goepel v. National Postal Mail Handlers Union*, 36 F.3d 306, 313 (5th Cir. 1994) (breach of contract claim by enrollee to recover benefits). *But see Caudill v. Blue Cross & Blue Shield of North Carolina*, 999 F.2d 74, 78-79 (4th Cir. 1993). The other cases on which Empire relies are also inapposite. *In MedCenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994), the Eighth Circuit found that federal law applied pursuant to FEHBA's partial preemption provision because the contract provisions had been shown to conflict with the applicable state law. *Id.* at 866-67. In *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572 (11th Cir. 1985), the plaintiff directly challenged OPM's decision to approve a change in a benefits plan. *Id.* at 1575. Here, however, Empire seeks to enforce the terms of the Plan, not to challenge the validity of any federal agency action.

Finally, Empire argues briefly that federal law preempts its state law claims. FEHBA's partial preemption provision does not create jurisdiction over this lawsuit. Unlike ERISA, FEHBA preempts state law only if that law is inconsistent with the terms of a FEHBA benefit or coverage contract.[2]

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[2] Empire omits from its argument -- and from its quotations -- the text of the statute which provides that preemption exists only "to the extent that such [State or local] law or regulation is inconsistent with such contractual provisions." 5 U.S.C. § 8902(m)(1).

See 5 U.S.C. § 8902m(1). Since there has been no identification of inconsistency here, there is no preemption.

Conclusion

This breach of contract and declaratory judgment action between private parties does not raise a federal question. The motion to dismiss for lack of subject matter jurisdiction is granted. The Clerk of Court shall close the case.

SO ORDERED:

Dated: New York, New York
September 18, 2003

Denise Cote
United States District Judge

APPENDIX E

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE,
d/b/a/ Empire Blue Cross and Blue Shield,

Plaintiff,

- against -

DENISE FINN MCVEIGH, as administratrix of the Estate of Joseph E. McVeigh,

Defendant.

JUDGMENT
(03 CIVIL 2728 (DLC)

Defendant having moved to dismiss for lack of subject matter jurisdiction and the matter having come before the Honorable Denise Cote, United States District Judge, and the Court, on Sept. 18, 2003, having rendered its Opinion (89067) and Order granting the motion to dismiss for lack of subject matter jurisdiction, and closing the case, it is,

ORDERED, ADJUDGED AND DECREED: That for the reasons stated in the Court's Opinion (89067) and Order, dated Sept. 18, 2003, defendant's motion to dismiss for lack of subject matter jurisdiction is hereby granted and the case is closed.

Dated: NYC, NY
September 23, 2003

J. Michael McMahon
Clerk of the Court

BY: /s/
Deputy Clerk

APPENDIX F

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 03-3098

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross and Blue Shield,

Plaintiff-Appellant,

v.

DENISE FINN MCVEIGH, as administratrix of the Estate
of Joseph E. McVeigh,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE SOUTHERN
DISTRICT' OF NEW YORK

BRIEF FOR THE UNITED STATES AS AMICUS
CURIAE SUPPORTING APPELLANT'S PETITION FOR
REHEARING AN RE HEARING EN BANC

STATEMENT OF INTEREST OF THE UNITED STATES

The United States respectfully submits this brief as amicus curiae in support of appellant' petition for rehearing and rehearing en banc. This suit implicates critical aspects of the program under which the federal government provides health insurance benefits to its own employees. In concluding that the suit presented no federal question conferring jurisdiction on the district court, the panel misapprehended the nature of the contract at issue in this suit, which determines the rights, benefits and duties of program enrollees, insurance carriers, and the federal government itself. Its decision conflicts with authoritative decisions of other courts of appeals that have addressed this issue and presents a question of exceptional importance warranting further review. *See* Fed. R. App. P. 35(b)(1)(B).

The Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901 *et seq.*, establishes a comprehensive scheme for the provision of health care benefits to federal employees, annuitants, and their families. Pursuant to the statute, the federal government contracts with various carriers, including the Blue Cross Blue Shield Association, to offer health benefits plans meeting standards established by the government and contained in the contracts. The federal government pays the greater part of the premiums which, along with the enrollee's share, are deposited into the Federal Employees Health Benefits Fund ("Fund") in the United States Treasury. Blue Cross draws against the Fund on a "checks-presented" basis to pay for enrollees' covered health care services. Any balance in the Fund is the property of the government. The carrier's profit, if any, comes from a negotiated service charge.

The government contract establishes not only the rights and duties of the government and carrier, but also the benefits and responsibilities of enrollees. An enrollee's right

to benefits under the terns of the contract is qualified by the duty to make reimbursement when the enrollee receives payment for the same illness or injury for which he has received benefits. The contract requires such repayment and also requires the carrier to seek reimbursement if repayment is not made voluntarily.

In this suit, the carrier sought to meet its contractual responsibilities by enforcing an enrollee's responsibility to make reimbursement for benefits received. A divided panel of this Court held that the carrier's claim does not arise under federal law and may not proceed in federal court. That holding conflicts with decisions of three other circuits. *See Blue Cross and Blue Shield of Illinois v. Cruz*, __ F 3d __, 2005 WL 129769 (7th Cir. Jan. 24, 2005); *MedCenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994); *Caudill v. Blue Cross & Blue Shield of North Carolina*, 999 F.2d 74 (4th Cir. 1993).

The panel majority departed from settled principles of law. Federal question jurisdiction exists if federal law either creates the cause of action or is a "necessary element" of the claim for relief. *Christianson v. Colt Indus. Operating Group*, 486 U.S. 800, 808 (1988). Under either prong of this inquiry, jurisdiction exists here.

As the Supreme Court explained in *Jackson Transit Auth. v. Local Division 1285*, 457 U.S. 15, 23 (1982), private suits to enforce contracts "contemplated by federal statutes" state a federal claim as long as Congress intended that the contracts be "creations of federal law" and that "the rights and duties contained in those contracts be federal in nature." The federal character of FEHBA contracts should be beyond question. The federal government itself is a party to the FEHBA contracts, which are the means by which the federal government provides health care benefits to its own employees and annuitants. The contracts establish the terms on which benefits are paid, and disputes regarding the

entitlement to benefits are resolved in federal administrative proceedings followed by federal court review. The duty to make *repayment* stems from the same contract and presents a federal question just as clearly as the right to receive benefits in the first place.

Alternatively, federal jurisdiction plainly exists under the second prong of *Christianson*. Whether repayment is owed turns on the application and interpretation of the federal contract that defines the enrollee's right to benefits and duty to make repayment. Because the contract is governed by federal law, federal law is a necessary element of the claim for relief.

STATEMENT OF FACTS

A. The Federal Employees Health Benefits Act.

Congress enacted the Federal Employees Health Benefits Act to establish a comprehensive program that would "assure maximum health benefits for employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959), *reprinted in* 1959 U.S.C.C.A.N. 2913, 2916. Today, approximately four million enrollees and their families receive health insurance through plans under FEHBA, at a total cost of about $27 billion per year in premiums, $20 billion of which is paid by the federal government.

The FEHBA delegates broad authority to the Office of Personnel Management ("OPM") to administer the Federal Employees Health Benefits Program, *see* 5 U. S. C. §§ 8901-13, and to promulgate regulations necessary to carry out the statute's objectives, *see id.* § 8913. In particular, the statute gives OPM authority to contract with carriers to offer health benefits plans available to federal employees, annuitants, and dependents. *Id.* §§ 8902, 8903. Such plans must meet criteria established by OPM, and the contract must contain "a detailed statement of benefits offered and shall include such

maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable." *Id.* § 8902(d). Enrollees are bound by the contract's terms. *See Christiansen v. National Sav. & Trust Co.*, 683 F.2d 520, 530 (D.C. Cir. 1982).

By statute, the government and the enrollee share responsibility for premiums payable to the plan. 5 U.S.C. § 8906. The employing agency (or OPM for annuitants) pays 72% to 75% of the premium as part of its payroll costs funded by general appropriations. *Id.* §§ 8906(b)(1), (b)(2), (f). Premiums are deposited into a special Treasury fund called the Federal Employees Health Benefits Fund. *Id.* § 8909(a).

Under the type of plan at issue in this litigation, the carrier draws against the Fund on a "checks-presented" basis to pay for covered health care services. *Id.* § 8909(a); 48 § C.F.R. 1632.170(b). Any balance in the Fund is not the property of carrier. Rather, the carrier's profit, if any, comes from a negotiated service charge. *See National Assn of Postal Supervisors v. United States*, 21 Cl. Ct. 310, 315 (1990) ("The service charge is the only profit element of FEHBA. * * * [The] carrier may not make a profit on the premium charges themselves."), *aff'd mem.*, 944 F.2d 859 (Fed. Cir. 1991); *see also* 48 C.F.R. § 1615.902. Any surplus in a plan's contingency reserves may be used, at OPM's discretion, to defray future rates, reduce future government and employee contributions, increase plan benefits, or refund the monies to the government and plan enrollees. 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2).

The government ultimately decides whether a claim for medical service should be paid under the program. 5 U.S.C. § 8902(j). If a carrier denies payment of a claim, the enrollee may seek OPM review. 5 C.F.R. § 890.105(a)(l). OPM's determinations are subject to judicial review in

federal court under the Administrative Procedure Act. *See, e.g., Muratore v. OPM*, 222 F.3d 918, 920 (11th Cir. 2000).

The FEHBA expressly provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m). This provision was enacted "to establish uniformity in Federal employee health benefits coverage," H.R. Rep. No. 95-282, 95th Cong., 1st Sess., at 1 (1977), and broadened in 1998 "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," H.R. Rep. No. 105-374, at 9 (1997).

B. The OPM Contract With Blue Cross Blue Shield.

The largest plan in the Federal Employees Health Benefits Program is the Blue Cross Blue Shield Service Benefit Plan. Pursuant to 5 U.S.C. § 8902, OPM has entered into annual contracts with the Blue Cross Blue Shield Association acting on behalf of a number of Blue Cross Blue Shield affiliates. The contract between the government and Blue Cross establishes the rights and duties of enrollees. The contract, like contracts with other carriers, includes a reimbursement provision requiring enrollees who receive compensation from a third party for an injury or illness to refund benefits paid.[1] Where enrollees do not return monies voluntarily, the

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[1] The provision is reproduced at J.A. A785 and states in relevant part:

(footnote continued on next page)

contract requires Blue Cross to make "a reasonable effort to seek recovery of amounts it is entitled to recover in cases which are brought to its attention," J.A. A140, and to "subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract," *id.*

C. Proceedings To Date.

Empire brought this action to enforce that reimbursement requirement. The complaint invoked the district court's federal question jurisdiction and alleged that the action was founded on FEHBA, on federal contracts and regulations established pursuant to FEHBA, and on the federal common law. The district court dismissed the action, holding that Empire's suit does not arise under federal law.

A divided panel of this Court affirmed. The panel majority believed that federal question jurisdiction turns on whether Empire could identify an actual, significant conflict between the operation of New York law and the federal interest in the uniform enforcement of FEHBA contract terms. Because no such conflict was identified, the Court held that there is no subject matter jurisdiction. In dissent, Judge Raggi concluded that there is federal question jurisdiction because

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(footnote continued from previous page)

> If another person or entity * * * causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:
>
> All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to amounts for benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.

federal common law governs all disputes involving the enforcement of FEHBA contracts.

ARGUMENT

A district court has federal question jurisdiction under 28 U.S.C. § 1331 if federal law creates the cause of action or if federal law is a "necessary element" of the claim for relief. *Christianson v. Colt Indus. Operating Group*, 486 U.S. 800, 808 (1988). The present suit satisfies both prongs of that inquiry.

A. Federal Law Creates the Cause of Action.

As the Supreme Court explained in *Jackson Transit*, suits to enforce contracts "contemplated by federal statutes" set forth federal claims and state federal causes of action if Congress intended that the contracts be "creations of federal law," and that "the rights and duties contained in those contracts be federal in nature." 457 U.S. at 22-23.[2] As in *Jackson Transit*, there is no question that Congress intended FEHBA contracts to be enforceable. *See id.* at 20-21. And the federal character of FEHBA contracts is evident. The Jackson Transit standard is plainly satisfied where the United States itself is a party to the contract, the applicable statute makes clear that the contract is governed by federal law, and the suit is brought either by the United States or, as here, by a party to the contract pursuant to its right and obligation to enforce the contract on behalf of the United States.

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[2] *See also, e.g., International Ass'n of Machinists v. Central Airlines, Inc.*, 372 U.S. 682, 691 (1963) ("It is federal law which would determine whether a contract [made pursuant to the Railway Labor Act] is valid and enforceable according to its terms."); *Verizon Maryland, Inc. v. Global Naps, Inc.*, 377 F.3d 355, 362-66 (4th Cir. 2004) (applying the *Jackson Transit* framework to contracts made pursuant to the Telecommunications Act of 1996).

Although *Jackson Transit* concluded that the contract at issue in that case did not arise under federal law, its analysis leaves no doubt that the opposite conclusion is required here. *Jackson Transit* considered a contract between a local transit authority and its employees. The local transit authority had acquired the failing transport company with the assistance of federal funds provided under the Urban Mass Transportation Act of 1964. As a condition on the receipt of federal funds, the local transit authority was required to make arrangements to preserve the transit workers' collective bargaining rights. *See* 457 U.S. at 16.

The Supreme Court observed that it was not apparent from the face of the statute whether the private party contract dispute would arise under federal law, but found that the legislative history of the statute was "conclusive" in demonstrating Congress's intent that state law govern, *id.* at 24, stressing that Congress had not intended to disturb the National Labor Relations Act's exemption for labor relations between local governments and their employees, *see id.* at 23.

The regulatory scheme established by the FEHBA and the contract authorized by that statute are in stark contrast to the provisions at issue in *Jackson Transit*. The FEHBA is a comprehensive program governing the health insurance of federal employees, annuitants, and their families. The FEHBA contracts define rights and obligations of the federal government, the carriers and the enrollees. The contract defines the right of an enrollee to receive benefits in the first instance, and also defines the enrollee's obligation to repay those benefits in some circumstances. It is settled that disputes about *payment* of benefits present a federal question. Such disputes are resolved by OPM in administrative proceedings subject to federal court review. *See, e.g., Muratore v. OPM*, 222 F.3d 918, 920 (11th Cir. 2000). The duty to make *repayment*, which arises from the

same contract, likewise presents a federal question. When the enrollee does not make repayment voluntarily, the carrier, in fulfillment of its own obligations under the contract, *see* J.A. A 140, may bring suit against the enrollee to enforce the enrollee's responsibilities under the contract. The route of resolution is different from the means for resolving initial payment disputes, but the federal nature of the obligation to make repayment is issue is just as clear as the federal nature of the right to receive the benefits in the first place.

Nor is there any doubt of the federal government's interest in the enforcement of repayment as well as payment obligations. Benefits payments derive from accounts that are funded and administered by the United States and maintained on the books of the United States Treasury. Payments to the carrier are made on a "checks-presented" basis, and the carrier has no property interest in any balance remaining in the Treasury fund after benefits are paid out and reimbursements received. The requirement that enrollees reimburse the carrier for monies obtained in tort suits is thus a critical feature of the federal health benefits program that inures to the benefit of the government.

If the reimbursement provision were contained in the statute or regulations there could be no dispute as to federal jurisdiction. The result does not change because the requirement is found in the government contract. It is black-letter law that the "obligations to and rights of the United States under its contracts are governed exclusively by federal law." *Boyle v. United Technologies Corp.*, 487 U.S. 500, 504 (1988). As the Supreme Court has stressed: "The validity and construction of contracts through which the United States is exercising its constitutional functions, their consequences on the rights and obligations of the parties, the titles or liens which they create or permit, all present questions of federal law not controlled by the law of any

state." *United States v. Allegheny County*, 322 U.S. 174, 183 (1944), *overruled on other grounds*, *United States v. City of Detroit*, 355 U.S. 466 (1958); *see also Clearfield Trust Co. v. United States*, 318 U.S. 363, 366-67 (1943).

Indeed, the FEHBA expressly provides for field preemption, stating that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m). Thus, only federal law may govern FEHBA contracts. As the provision's history makes clear, *see* p.6, *supra*, absent such field preemption "[f]ederal employees in different states would have different reimbursement obligations and hence different net benefits," a result "contrary to the uniformity goal of FEHBA in general and its preemption provision in particular." *Cruz*, 2005 WL 129769, at *4; *see also* slip op. at 42-43 (Raggi, J., dissenting); *Botsford v. Blue Cross & Blue Shield of Montana*, 314 F.3d 390, 394 (9th Cir. 2002).

B. Federal Law Is A Necessary Element Of Empire's Claim.

Because the claim in this suit states a federal cause of action, jurisdiction exists on that basis. Jurisdiction also exists because federal law is a "necessary element" of Empire's claim. *Jones v. R.R. Donnelly & Sons Co.*, 124 S. Ct. 1836, 1842 (2004) ("[A] claim arises under federal law if federal law provides a necessary element of the plaintiff's claim for relief.").[3] The existence of the FEHBA contract

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[3] *See also, e.g., City of Chicago v. International College of Surgeons*, 522 U.S. 156 (1997); *Merrell Dow Pharmaceuticals v. Thompson*, 478 U. S. 804, 808-809 (1986); *Smith v. Kansas City Title & Trust*, 255 U.S. 180 (1921); *Verizon*, 377 F.3d at 364-65.

and the validity and meaning of its reimbursement requirement are necessary elements of Empire's claim. And as explained above, the "validity and construction" of FEHBA contracts, including the "liens which they create or permit, all present questions of federal law not controlled by the law of any state." *Allegheny County*, 322 U.S. at 183. In light of the enormous federal interest in the uniform application of its benefits contracts, even if state law could be thought to provide Empire's bare cause of action, federal law would provide the substantive law governing the interpretation of the contract.

C. The Panel's Decision Misapprehends The Relevant Legal Inquiry And The Nature of the Federal Interest.

The panel's central premise is that the existence of a federal cause of action depends on whether a conflict between federal interests and state law can be identified in a particular case. The Supreme Court made clear in *Jackson Transit* that this is not the relevant inquiry with respect to private contract suits, even when the United States is not a party to the contract. Indeed, if the rights and duties of carriers and enrollees were set out in regulations rather than in the governing contract, no one would argue that the validity and meaning of the federal regulations would present a federal question only if the regulations conflicted with state law.

The panel's error may reflect a misunderstanding of the role of the governing contract and the extent to which it establishes the rights and duties of enrollees as well as the government and the carriers. It may also reflect a misunderstanding of the FEHBA payment scheme, in which Blue Cross draws payments from a designated Treasury fund on a "checks presented" basis and has no property interest in the money left in the fund at the end of the fiscal year.

The conflict between federal and state law was significant in *Boyle* because *Boyle* was *not* a suit to enforce a government contract, but a state-law tort claim against a government contractor. The state-law claim was displaced by federal common law because of its indirect potential to undermine the rights and duties created by the federal contract. Likewise, *Woodward Governor Co. v. Curtiss-Wright Flight Sys.*, 164 F.3d 123, 127 (2d Cir. 1999), was not a suit to enforce a government contract but a suit to enforce a subcontract. This Court held that the subcontract was "too far removed" from the federal interests to warrant the application of federal common law. Neither decision casts doubt on federal jurisdiction here.

Finally, contrary to the panel's suggestion, slip op. 10-13, the terms of a federal contract may displace state law just as surely as if those terms were reflected in federal regulations. The FEHBA is a valid exercise of Congress's spending power, and any state law that interferes with the purposes of the program is properly displaced. A FEHBA contract is not a "privately-negotiated contract," *id.* at 11, but a government contract, made pursuant to federal statute and regulations, that governs the rights and benefits of federal enrollees. State law must give way to the extent that it impairs the enforcement of any federal right or program, including a procurement program. *See Allegheny County*, 322 U.S. at 183 ("Procurement policies so settled under federal authority may not be defeated or limited by state law. The purpose of the supremacy clause was to avoid the introduction of disparities, confusions and conflicts which would follow if the Government's general authority were subject to local controls."); *M'Culloch v. Maryland*, 17 U. S. 316, 427 (1819) ("It is the very essence of supremacy . . .to modify every power vested in subordinate governments, as to exempt its own operations from their own influence."); *Boyle*, 487 U.S. at 512 (finding preemption based on conflict

between state law and the terms of a federal procurement contract).

CONCLUSION

For the foregoing reasons, the panel decision should be vacated and the judgment of the district court reversed.

Respectfully submitted,

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FEBRUARY 2005

05-200

No.

IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,

Petitioner,

- against -

DENISE FINN MCVEIGH, as Administratrix
of the Estate of Joseph E. McVeigh,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the court of appeals erred in affirming a district court finding of lack of subject matter jurisdiction under the pleadings and facts presented in this case?

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STATEMENT OF THE CASE

This is a simple contract dispute over the amount of money Empire is owed in reimbursement from the proceeds of the settlement of a personal injury case.

Contrary to Empire's sweeping assertions, this simple monetary dispute, that could have easily been handled in state court or as an Estate claim, does not involve any compelling federal interest and certainly does not deserve the attention of this Court.

On April 18, 2003, Empire filed its complaint in the United States District Court For the Southern District of New York[1] seeking to obtain reimbursement of $157,309.06 it paid in medical benefits on behalf of a now deceased, former enrollee in it's health benefits plan, from the proceeds of a settlement obtained on behalf of the former enrollee and his Estate. J.A. A6.

Despite the fact that Empire's complaint claims to be based on subrogation and right-of-recovery provisions of its Service Benefits Plan, the complaint seeks a formal "lien" against the settlement proceeds and also appears to seek reimbursement not only from the enrollee's Estate, but also from his widow, individually. In addition, it's claim of $157,309.06 appears to contain triple billings and other charges that would

---

[1] It is noted, and of some significance, that, not only did Empire consent in Court to the settlement of the underlying personal injury case, but also made the voluntary election to bring this action in federal court, as opposed to state court, or as a claim against the Estate in Surrogates' Court. J.A. A914-917.

not be recoverable because they are not related to medical treatment rendered to the former enrollee as a result of injuries sustained in the accident. J.A. A831-834.

The Respondent did not serve or file an Answer to Empire's complaint, but rather moved to dismiss the action pursuant to FRCP Rules 12 and 56 for lack of subject matter jurisdiction, failure to state a claim, summary judgment and expiration of the Statute of Limitations. J.A. A811-827.

The Respondent has never denied that Empire has a right of subrogation, nor has the Respondent ever denied that Empire has a right of recovery. What the Respondent disputes is Empire's right to a "lien"; its right to a recovery against the widow individually and, most importantly, its right to recover the full amount of its claim. J.A. A807, 824-826, 836.

On September 18, 2003, the district court issued an Opinion & Order (App. D, 54a-62a), dismissing this action for lack of subject matter jurisdiction, stating that this "breach of contract and declaratory judgment action between private parties does not raise a federal question." Id, 62a.

The Petitioner appealed from that Opinion & Order and, on January 14, 2005, the Second Circuit Court of Appeals affirmed the dismissal. Two of the three Circuit Judges of the Second Circuit found, under the specific facts of this case, that the District Court did not have subject matter jurisdiction over this case under either the FEHBA statute as written, nor the two-pronged test enunciated by this Court in Boyle v. United Techs. Corp., 487 U.S. 500 (1988).

On this application, the Petitioner does not argue that the FEHBA statute is unconstitutional, nor does the Petitioner argue

that the Boyle test was misstated by the Second Circuit. What Empire argues is that the Second Circuit made erroneous factual findings and "seriously errs in both its statutory and Boyle analyses" in it's jurisdictional analysis of the facts of this particular case. Pet. 10.

The Petitioner, however, overlooks the fact that the Second Circuit decision was case-specific and limited to the facts and proof presented to it in this particular case, principally Empire's own failure, in this case, to properly plead or prove the elements necessary to satisfy the Boyle test, so as to invoke the subject matter jurisdiction in the federal courts. More specifically, it was Empire's failure to properly plead or demonstrate any "actual, significant" conflict between New York State law and the federal interests underlying the FEHBA recovery provisions, so as to satisfy the second prong of the Boyle test, that resulted in the dismissal of its case.

There was no error by the Second Circuit. The lack of jurisdiction was based upon Empire's own failure of proof.

The Petitioner further argues some "compelling federal interest" in this simple monetary dispute and that the Second Circuit decision "throws into disarray a nationwide federal program affecting millions of people." Pet. 13.

However, here again, Empire has failed to present any proof whatsoever to support such a catastrophic assertion. Such a claim amounts to no more than sheer speculation.

It is submitted that the factual, and case-specific, decision-making of the District Court and the Second Circuit should not be reviewed by this Court. It is further submitted that the Petitioner fails to demonstrate any compelling reason,

beyond mere speculation, to justify discretionary review by this Court and that, in any event, the Court of Appeals decision, based upon the specific facts and proof in this case, was correct.

CLARIFICATION OF THE RECORD

The Petitioner, in an effort to convince this Court that there is some compelling federal interest in this simple monetary dispute, repeatedly refers to its Service Benefit Plan as a "federal government contract", whose terms "were promulgated by OPM and are part of the government contract". Pet. i, 2, 3.

However, there is no proof in this record to demonstrate that the federal government, including the OPM, or any federal statute, actually set forth the terms of Empire's Service Benefit Plan. Contrary to the Petitioner's assertions, it appears that the terms of that Plan were promulgated by Empire.[2]

REASONS FOR DENYING THE WRIT

1. EMPIRE HAS NOT ARTICULATED A COMPELLING REASON TO JUSTIFY DISCRETIONARY REVIEW BY THIS COURT

"Review on a writ of certiorari is not a matter of right,

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[2] as demonstrated by the fact that the "Statement of Benefits" was not part of the OPM-BCBSA contract, but was incorporated by reference. In addition, the Plan terms speak of a "lien" which is an unauthorized expansion of the FEHBA statute.

but of judicial discretion". "A petition for a writ of certiorari will be granted only for compelling reasons." Sup. Ct. R. 10.

The Petitioner is claiming in this case some "compelling" federal interest that deserves the attention of this Court because the lower court decision "potentially throws into disarray a nationwide program affecting millions of people".

The Petitioner offers no proof whatsoever to support such a sweeping claim; not one single example of how adjudication of these claims in the state courts resulted in any divergent decisions among the states; not one single example of any "uncertainty and disparate treatment that will result if the court of appeals' decision is allowed to stand"; not one example of any "discrepancy in treatment between the resident of the Second Circuit and other FEHBA enrollees." Pet. 13-14. The entire discussion by Empire of the claimed "disarray ... affecting millions of people" has no factual basis whatsoever.

Such a claim is nothing more than mere speculation "about the various harms that 'might' result from state-by-state adjudication of suits brought by insurance carriers under FEHBA-authorized contracts." App. 7a.

As correctly found by the Second Circuit, there is nothing to support the Petitioner's audacious claim that there are any vast differences in the common law of contracts among the states, that would result in divergent decisions in different cases. App. 8a. As stated by this Court, "[b]ecause contract law is not at its core diverse, nonuniform, and confusing", there (is) "no large risk of nonuniform adjudication inherent in [s]tate-court enforcement of the terms of a uniform agreement ... entered into ... nationwide." See American Airlines v. Wolens, 513 U.S. 219, 233 n.8 (1995).

There is nothing in this simple contract claim, beyond sheer speculation, to show any compelling reason for this Court's discretionary review of this case.

2. EMPIRE HAS NOT SHOWN A REAL CONFLICT BETWEEN THE CIRCUITS, ONLY DIFFERING RESULTS BASED UPON DIFFERENT FACTS

In support of this petition, Empire claims a stark conflict between the Second Circuit decision and the decisions of two other circuits. Pet. 10-12. It is submitted however that the opinions asserted in the several Circuits are not as dissimilar as Empire claims.

In all of the cases, when analyzing the second prong of the Boyle test, namely whether there was a showing of an "actual, significant" conflict between state law and the federal interests underlying the FEHBA recovery provisions so as to confer subject matter jurisdiction, the several Circuits correctly examined the specific facts in their respective cases in making their analysis and arrived at different decisions based on those facts. While they arrived at different results, they did so correctly, based on the specific facts before them.

Indeed, the Second Circuit acknowledged that Empire might have achieved a different result had it properly pleaded and proved it's case, when the Court stated, "We recognize the possibility that at a later stage in the proceedings, a significant conflict might arise between New York state law and the federal interests underlying FEHBA, such that the dispute would satisfy both prongs of Boyle." App. 8a. The Court, however, correctly found that "This possibility, however, is insufficient to confer federal jurisdiction." App. 8a. (See also, the concurring opinion of Circuit Judge Sack, where he states that the Court's decision

in this case is based, correctly, on the specific facts of this case, as presented to it by the Petitioner, and that as such, when presented with a different situation, the Court would not necessarily be bound by their analysis. Pet. App. 26a.)

In both of the cases relied upon by the Petitioner to show a conflict between Circuits, namely Cruz and Ochs, the Seventh Circuit and Eighth Circuit respectively were provided with, and based their decisions on, specific state laws that significantly conflicted with the FEHBA recovery provisions.

In this case, the Petitioner, unlike in the Cruz and Ochs cases, has never identified to any court, including this Court, any state law that is alleged to be in conflict with the Federal statute, or any Federal policy or objective. In this regard, the Second Circuit decision specifically found that "regardless of the strength or importance of the federal interests at stake, Empire has failed to demonstrate that the actual operation of New York state law creates an 'actual, significant conflict' with those interests" and that "Tellingly, Empire's briefs on appeal fail to mention a single state law or state-imposed duty that runs contrary to the federal interests asserted in this case." App. 7a.

As such, it is clear that it is Empire's own failure of proof, in this specific case, that distinguishes this case from the cases in the Seventh and Eighth circuits.

3. EMPIRE HAS FAILED TO SHOW A CLEAR AND MANIFEST INTENT ON THE PART OF CONGRESS TO CONFER JURISDICTION OVER PRIVATE BREACH OF CONTRACT ACTIONS BETWEEN PRIVATE INSURANCE COMPANIES AND THEIR BENEFICIARIES

When Congress enacted the FEHBA statute, it explicitly gave the district courts original jurisdiction over FEHBA-related civil actions or claims when those actions or claims are "against the United States". What Congress did not do in the FEHBA statute, although it clearly could have, was to create a private right of action in the federal courts for a health insurer to assert the type of claim that is asserted by Empire in this case.

In contrast, and as a striking example of Congressional intent, when Congress enacted the ERISA statute, 29 U.S.C. §1132(e), it explicitly gave the district courts "exclusive jurisdiction of civil actions under this subchapter ..."

While the grant of federal jurisdiction over one category of claims does not necessarily strip federal courts of their jurisdiction over another category of claims, it does clearly demonstrate that Congress considered jurisdictional issues when it enacted FEHBA and ERISA, and that it did not hesitate to expressly confer jurisdiction where it found it necessary to do so, i.e. in ERISA, but not in FEHBA.

In providing in FEHBA for an express grant of jurisdiction in the district courts for actions "against the United States", there is a strong presumption that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly, Mertens v. Hewitt Assocs., 508 U.S. 248 at 254, particularly in light of its express grant of "exclusive jurisdiction of (all) civil actions" in ERISA.

Stated differently, it is anything but clear that Congress intended for there to be jurisdiction in the federal courts for contract disputes under FEHBA, otherwise Congress could have expressly conferred jurisdiction as it did in the ERISA statute.

To the contrary, it appears clear that Congress intended for the interpretation and application of the particular provisions of health insurance contracts, issues that are traditionally regulated by the states, to be heard in state and not federal court.

As so succinctly stated by the Second Circuit,

> "If Congress intended for this case to be heard in federal court, it could have created a private right of action for suits against FEHBA beneficiaries; it could have vested jurisdiction over these claims in the federal courts; or it could have included an affirmative grant of authority to the federal courts to create a body of federal common law. Congress did none of these things." App. 24a.

CONCLUSION

Empire, by its counsel, consented in state court to the settlement of the underlying personal injury action, with the proviso that it would assert its reimbursement claims in a separate action within 30 days. J.A. A914-917. Empire could have asserted it's reimbursement claim in the state court where that action was pending, or in the state Surrogates' Court (as a claim against the Estate), but instead made the voluntary election to bring this action in the federal district court, subject to federal jurisdiction to hear the claim. J.A. A914-916.

When faced in the court of its choice to an objection to jurisdiction, Empire totally failed to plead, prove, demonstrate or even mention any facts that would have conferred jurisdiction in that court to hear that claim, i.e. facts establishing an actual conflict between state law and the federal interests that would

have satisfied the second prong of the Boyle test.

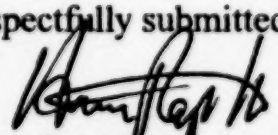
And, when faced with a dismissal of its case on jurisdictional grounds, it implores this Court to hear the case, based upon unsubstantiated speculation that this dismissal will somehow throw the federal health benefit system into chaos.

The dispute in this case does not involve the interpretation of any federal statute or federal law; it does not involve the application of any federal law, nor any conflict between state law and federal interests; nor will the dismissal of this case, being case-specific, throw the federal health benefit system into chaos.

In truth, the dispute in this case is a simple contract dispute over money that could have easily and quickly been resolved in state court. In essence, the only reason we are now before this Court is because Empire wanted a sweeping federal appellate decision placing all health benefit disputes in federal, as opposed to state court, regardless of the facts, or merits, of its claims.

Respectfully, the Petition should be denied.

Respectfully submitted,



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IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,

Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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Empire HealthChoice Assurance, Inc. ("Empire") respectfully files this reply to Respondent's brief in opposition to Empire's petition for a writ of certiorari.

ARGUMENT

A. There Is a Conflict Among the Circuits on the Question Presented

Respondent contends that there is no real disagreement among the circuits on the question whether the federal courts have jurisdiction over FEHBA reimbursement controversies, "only different results based upon different facts." Br. in Opp. at 6. In particular, Respondent contends that Empire has not alleged or proven any "'actual, significant' conflict between state law and the federal interests underlying the FEHBA recovery provisions so as to confer subject matter jurisdiction," whereas the decisions from other circuits supposedly did identify such conflicts. *Id.* (quoting *Empire*, Pet. App. 6a-7a).

But Respondent errs on several fronts. First of all, she focuses solely on the portion of the Second Circuit decision's dealing with *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988), ignoring the circuit splits created by the other parts of the court of appeals' determination. Then, even with respect to *Boyle*, Respondent miscomprehends the Second Circuit's decision, overlooks the Fourth Circuit decision that creates a circuit conflict on the *Boyle* issues, and ultimately disregards the record in contending that Empire's case suffered from a failure of proof. In the end, even limiting the discussion just to *Boyle*, the outcome in this case as well as the reasoning is irreconcilable with the decisions of the other courts of appeals.

1. Respondent Ignores the Circuit Splits Unrelated to *Boyle*

Respondent's presentation relates almost exclusively to just one of the three bases reached by the Second Circuit for rejecting federal jurisdiction. Respondent focuses on whether federal common law governs the controversy pursuant to *Boyle*

v. United Technologies Corp., 487 U.S. 500 (1988). Only in its *Boyle* analysis did the court of appeals discuss any need for an "actual, significant" conflict before federal common law would displace state law. Yet, in its original decision, the court of appeals also addressed, and rejected, federal jurisdiction based on preemption under FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1); in its rehearing determination, the court of appeals rejected jurisdiction founded on *Jackson Transit Authority v. Local Division 1285*, 457 U.S. 15 (1982).

There is no requirement of any conflict between state and federal law under FEHBA's preemption provision. Congress expressly removed that requirement by amending the statute in 1998. *See* Pet. 16. Additionally, the test for jurisdiction under *Jackson Transit* rests on Congress's intent, most specifically on whether Congress intended that the rights and duties contained in a contract be "federal in nature." *Jackson Transit*, 457 U.S. at 23; *see also* Pet. 19-20. Thus, even if Respondent were correct that there is no "actual, significant" conflict between state and federal law in this case, but there were state-federal conflicts evident in the other relevant circuit decisions, it would still leave two decisional bases for review.

Indeed, the initial circuit conflict listed by Empire in the petition – the one between this decision and *Blue Cross Blue Shield of Illinois v. Cruz*, 396 F.3d 793 (7th Cir. 2005), *petition for cert. filed*, No. 04-1675 (June 6, 2005) – has nothing to do with *Boyle*. In *Cruz*, the Seventh Circuit found federal jurisdiction based on FEHBA's preemption provision, noting that it need not reach any *Boyle* issue. The Seventh Circuit neither identified nor required any actual, demonstrated conflict between a specific state law and federal interests; instead, it concluded that the objective of national uniformity embodied in FEHBA's preemption section mandated the preemption of all state law in the area, leaving federal common law to fill the void. Respondent seeks to distinguish *Cruz* on a basis entirely foreign to the Seventh Circuit's determination.

The Second Circuit recognized (on rehearing) that its decision and *Cruz* are irreconcilable (*see* Pet. App. 50a), which therefore puts Respondent in the untenable position of asserting that a circuit conflict does not exist when in fact the court whose decision Respondent seeks to uphold has itself identified the conflict. Furthermore, Empire also identified circuit splits created by the Second Circuit's FEHBA preemption holding that state laws of general application are not preempted. *See* Pet. 12. Respondent's assertions about *Boyle* in no manner would negate those circuit conflicts.

2. In Any Event, the Second Circuit's *Boyle* Analysis Generates Circuit Splits

Even with respect to the Second Circuit's *Boyle* analysis, Respondent overlooks the circuit decision that Empire has cited as conflicting with the Second Circuit's opinion. The Second Circuit was the first court in the FEHBA setting to require a conflict between a *specific* state law and federal interests before finding that federal common law governs the area. The Fourth Circuit, in *Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 79 (4th Cir. 1993), ruled that, "[w]hen the federal interest requires the application of a uniform rule, federal common law displaces state law entirely," even absent "any specific conflict between federal interest[s] and state law." The *Boyle* issue on which the circuits disagree, therefore, is whether a federal interest in uniformity alone is sufficient for the displacement of state law – with the Fourth Circuit saying it is, and the Second Circuit saying it is not. *See* Pet. 12 (noting Second Circuit's own statement that its decision conflicts with *Caudill*). It cannot be disputed that, in *Caudill*, no litigant identified a specific state law with which federal objectives conflicted; it was the entire body of state contract law that the Fourth Circuit deemed to collide with the federal desire for uniformity.

And on the application of *Boyle* itself, Respondent fails to recognize that Empire *did* identify a specific state law that

conflicts with federal objectives. In the district court, Respondent not only sought dismissal for lack of jurisdiction, but also summary judgment on the grounds that Empire's reimbursement claim was allegedly untimely under a 60-day New York statute of limitations. *See* J.A. A823-A824; *see also* Br. in Opp. at 2. The Service Benefit Plan's reimbursement provision contains no such limitations period. Respondent's reliance on the New York statute of limitations creates exactly the sort of "actual, significant" conflict with the federal interests that she contends must exist for *Boyle* to authorize the application of federal common law. While the Second Circuit concluded that this conflict was brought to its attention too late, Empire could not have predicted that the court of appeals would insist on a conflict with a specific state law as a necessity under *Boyle*. Empire raised the statute-of-limitations issue at the very first moment – *i.e.*, on rehearing – that anyone could have gleaned it would be relevant to the case's disposition.

In the end, though, the Second Circuit still would not have found federal jurisdiction even with the "actual, significant" conflict that Respondent says is needed. In its rehearing decision, the panel majority noted that, "[i]n any event, the argument [about the conflict created by the statute of limitations] could not have made a difference under the original opinion's analysis." Pet. App. 48a n.3. This is because Judge Sotomayor originally found that, even with a conflict engendered by "a state law that was meant to advance a particular state policy," federal common law supposedly would only enter the case by way of a defense. Pet. App. 8a. Since federal jurisdiction must be founded on the well-pleaded complaint, not a defense, she thought it would then be left to the state courts to resolve the case based on federal common law. *See id.* at 8a-10a & n.4, 15a n.9.

The Second Circuit, then, because of its view of the well-pleaded complaint rule, would not find federal jurisdiction even with the sort of "actual, significant" conflict that Respondent

claims to have existed in *Cruz* and *MedCenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994). That in itself is a split in the circuits, given that both *Cruz* and *MedCenters* upheld federal jurisdiction.

B. The Question Presented Is of National Importance

Respondent contests that there are "compelling reasons" for review in this Court. Br. in Opp. at 5. The United States, however, has already emphasized the case's importance. At the rehearing stage in the court of appeals, the United States filed an *amicus* brief stating:

> This suit implicates critical aspects of the program under which the federal government provides health insurance benefits to its own employees. In concluding that the suit presented no federal question conferring jurisdiction on the district court, the panel misapprehended the nature of the contract at issue in this suit, which determines the rights, benefits and duties of program enrollees, insurance carriers, and the federal government itself. Its decision conflicts with authoritative decisions of other courts of appeals that have addressed this issue and presents a question of exceptional importance warranting further review.

Pet. App. 66a. It is not credible for Respondent to assert that there is no "'compelling' federal interest that deserves the attention of this Court," when the federal government – whose program is at issue in this case – has itself advocated otherwise. Br. in Opp. at 5.

Respondent next challenges Empire's assertion that the Second Circuit's decision potentially throws into disarray the FEHBA program. Respondent demands specific examples of how state court adjudication and the application of state law in FEHBA controversies would lead to "'uncertainty and disparate treatment'" or "divergent decisions among the states." *Id.* (quoting Pet. 13). Empire supplied those examples in the

Petition, but briefly reviews them further here. *See* Pet. 13 (noting that Second Circuit's reading of FEHBA's preemption provision leaves the government, carriers, and enrollees unable to predict whether various laws of general application are preempted).

For instance, this Court has long recognized that health plan beneficiaries in other federal programs often attempt to use state tort law and consumer protection laws as an end run around available, but more limited, federal remedies. *E.g.*, *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 207, 211 (1985) (finding that Labor Management Relations Act preempts state "tort of bad faith"). Resting on FEHBA's preemption clause, the courts previously have rejected efforts to apply similar state laws in the FEHBA context. *E.g.*, *Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 926 (9th Cir. 1987); *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1031-37 (E.D. Tenn. 1999); *Kight v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc.*, 34 F. Supp. 2d 334, 340-42 (E.D. Va. 1999). In light of the Second Circuit's decision, the prospect now is that, where a FEHBA enrollee is unhappy with the administration of a plan, he or she may seek to invoke state tort and similar laws to vindicate the grievance.

In addition, this Court established early on in its ERISA jurisprudence that state anti-discrimination laws cannot be used to expand the scope of coverage under an ERISA plan. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 (1983) (finding that ERISA preempts state human rights law that prohibited conduct allowed under federal law). Under the Second Circuit's reasoning, these state laws potentially can be used to expand the scope of coverage or perhaps even who can enroll in a plan, if the state requirement is contained in an anti-discrimination law of general application. That is particularly troubling because, when enacting FEHBA's original preemption clause, Congress expressly viewed as falling within FEHBA's preemptive ambit "State laws or regulations which

specify . . . extent of benefits, coverage of family members, age limits for family members or other matters relating to health benefits or coverage." H.R. Rep. No. 95-282, at 4-5 (1978), *reprinted in* 1978 U.S.C.C.A.N. 273.[1]

C. Empire Does Not Challenge Any Factual Findings

In an effort to muddle the legal issues presented to this Court, Respondent contends that Empire believes "the Second Circuit made erroneous factual findings." Br. in Opp. at 3. Empire asserts nothing of the sort. Empire maintains that the court of appeals misconstrued FEHBA's preemption provision and failed properly to apply *Jackson Transit Authority v. Local Division 1285*, 457 U.S. 15 (1982), and *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988). These are legal questions. To the extent any facts are pertinent, they are as stated in the complaint (since the case was resolved on a motion to dismiss) or as recognized by the lower courts. *See* Pet. App. 2a-4a.

What Empire does contest is the Second Circuit's *characterization* of the FEHBA contract and the Statement of Benefits incorporated into it as some "privately-negotiated contract." Pet. App. at 12a. The contract is a *government* contract, made pursuant to federal statute and regulations that govern the rights and benefits of federal enrollees. Moreover, the Statement of Benefits, by statute, reflects the benefits and other Plan provi-

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[1] Empire does not concede that these laws would apply, even if the Second Circuit's decision were to remain undisturbed. Empire would vigorously assert that traditional conflict preemption principles necessitate preemption even in the absence of an express preemption section. *See Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 873-74 (2000). But the point is that the applicability of state laws whose preemption previously had been settled would now be open to question (and their preemption would depend on establishing, under ordinary preemption principles, conflicts nowhere required under the preemption clause).

sions that OPM has selected. In this regard, FEHBA mandates that every FEHBA contract "shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as *the Office* considers necessary or desirable." 5 U.S.C. § 8902(d) (emphasis added). As such, the Statement of Benefits' "provisions are rules under the Administrative Procedure Act, 5 U.S.C. § 551(4)." *Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 80 (4th Cir. 1993); *see* 5 U.S.C. § 551(4) (defining rule as an agency statement prescribing or approving services or allowances and having prospective effect). Evincing that the Statement of Benefits is essentially a rule, not some private instrument, the D.C. Circuit (per Justice, then-Judge, Ginsburg) has noted that any challenge to the content of the Statement of Benefits is governed by the Administrative Procedure Act and its arbitrary-and-capricious review standard. *See Doe v. Devine*, 703 F.2d 1319, 1321, 1326 (D.C. Cir. 1983).

D. Congress Intended to Confer Federal Jurisdiction

Respondent's final argument relates to the merits of the Second Circuit's decision, not to the depth of the circuit split or to the national importance of the case. Respondent asserts that 5 U.S.C. § 8912, which provides for federal jurisdiction over FEHBA suits against the United States, forecloses jurisdiction over other FEHBA matters. Supposedly Congress cannot be said to have "intend[ed] to authorize other remedies" when it enacted that jurisdictional provision. Br. in Opp. at 8.

Respondent's argument is inconsistent with this Court's decision last Term in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 125 S. Ct. 2363 (2005). As noted in the petition (Pet. 21), the Court there squarely rejected the notion that lack of a federal statutory cause of action is somehow "dispositive" of federal question jurisdiction. *Id.* at 2370. *Grable*, like this case, was a suit between private parties; it was a quiet-title action commenced after an IRS sale of the property. Importantly, and also like in this case, there was no

statutory cause of action covering the case, but federal law did create a cause of action *if the government were the defendant*. *Id.* at 2370 n.4. The Court affirmed the lower courts' finding of federal question jurisdiction over the suit between private parties, emphasizing the "'federal interest at stake'" and particularly that "[t]he Government had a strong interest" in the case. *Id.* at 2367, 2370 (quoting *Merrell Dow Pharms., Inc. v. Thompson*, 478 U.S. 804, 814 n.12 (1986)).

Respondent's real complaint in opposing certiorari is that she believes it would have been simpler and cheaper to resolve the federal issues in a state forum, such as "in Surrogates' Court." Br. in Opp. at 1 n.1. Respondent ignores the benefit created by federal adjudication – namely, as noted in *Grable*, "the experience, solicitude, and hope of uniformity that a federal forum offers on federal issues." *Grable*, 125 S. Ct. at 2367. Empire is the master of its complaint, and it was entitled to bring the case in federal court, where a uniform body of federal common law could develop and govern.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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- against -

DENISE FINN MCVEIGH, as Administratrix
of the Estate of Joseph E. McVeigh,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY TO THE AMICUS CURIAE BRIEF OF THE UNITED STATES

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REPLY TO THE AMICUS CURIAE BRIEF OF THE UNITED STATES

This supplemental memorandum is respectfully submitted, pursuant to Rule 15.8 of this Court, to address an "intervening matter not available at the time of (our) last filing", namely the facts, positions and arguments of the United States relative to this petition for certiorari submitted by Empire Healthchoice Assurance, Inc. (Empire).

1. THE UNITED STATES BRINGS TO THE ATTENTION OF THIS COURT A CHANGE IN THE LAW THAT PROVIDES FURTHER EVIDENCE OF CONGRESSIONAL INTENT

As this Court is well aware, the FEHBA statute expressly provides for jurisdiction in the federal courts in cases "against the United States" (while not expressly providing for federal court jurisdiction in actions such as *McVeigh* [where the carrier brings suit against an enrollee]).

The United States now brings to the attention of this Court a fact not previously discussed, namely that OPM amended its regulations in 1995 to provide for suit by an enrollee against the OPM, rather than against the insurance carrier, thus making the action, in effect, "against the United States" and thereby invoking federal-question jurisdiction under that express jurisdictional statement in the FEHBA. (Amicus Curiae Br. 13-14 and footnote 7).

The United States further sets forth the fact that neither the OPM, nor Congress, has seen fit in the ten years since that amendment to take any action to expressly provide for jurisdiction when a carrier brings an action against an enrollee.

"There has been no change in the law, however, that would affect federal jurisdiction in FEHBA reimbursement cases, such as the instant case and *Ochs*." (Amicus Curiae Br. 14.)

What the United States has done in its Amicus Curiae Brief, perhaps inadvertently, is to provide further evidence that neither the Congress, nor OPM, intended for there to be federal court jurisdiction in actions by insurance carriers against enrollees, the exact position taken by *McVeigh*.

Both the United States and Empire are seeking for the Circuit Courts (and now this Court) to, in effect, legislate jurisdiction in the federal courts over actions by insurance carriers against enrollees, an action clearly not intended by the Congress.

It is submitted that this Petition should be denied.

2. THE UNITED STATES HAS NOT ARTICULATED A COMPELLING REASON TO JUSTIFY DISCRETIONARY REVIEW BY THIS COURT

In a glaring omission, the United States, in support of Empire's Petition, fails to present any evidence to articulate a compelling reason for this Court's discretionary review. While the United States provides general information concerning how the FEHBA program is funded, there are no specific facts or figures provided to in any way reflect or suggest how adjudication of reimbursement claims in state court, would, in any manner, effect the U.S. Treasury, or would, in any manner, effect the uniformity of the FEHBA program.

Instead, the United States makes the conclusory and unsupported claim that the *McVeigh* and *Cruz* decisions will somehow "threaten(s) the achievement" of national uniformity. (Amicus Curiae Br. 10-11).

However, the United States fails, as does Empire in it's petition, to offer anything beyond mere speculation to support such a claim. There is simply nothing in this record to support the argument that these circuit court decisions will "threaten" uniformity. Nor is there anything in this record to suggest that the state courts cannot uniformly adjudicate these simple contract claims and apply federal law in the process, if necessary.

There is nothing in this simple contract claim, beyond sheer speculation, to show any compelling reason for this Court's discretionary review of this case.

3. THE UNITED STATES HAS NOT SHOWN A REAL CONFLICT BETWEEN THE CIRCUITS, ONLY DIFFERING RESULTS BASED UPON DIFFERENT FACTS

The United States argues, as does Empire, that "the Second and Seventh Circuits reached diametrically opposed conclusions" in the *McVeigh* and *Cruz* decisions, respectively (Amicus Curiae Br. 10), and that "These two cases arise from remarkably similar facts" (Amicus Curiae Br. 11).

These arguments, however, are simply untrue. While both the *McVeigh* and *Cruz* cases involve similar fact patterns, there is one striking factual distinction between them that was

dispositive of both cases in the lower courts. Indeed, the United States itself sets forth the factual differences between the *Cruz* and *McVeigh* cases.

The United States describes a specific conflict between state and federal law in the *Cruz* case [namely the applicability of "the state 'common fund' doctrine, which Cruz asserted would have required Blue Cross to shoulder some of the attorney's fees" (Amicus Curiae Br. 8-9)]. At the same time, the United States, in the same way that Empire does, fails to identify any such conflict in the *McVeigh* case.

These two cases are not identical and were, in fact, decided on different facts, specific to each case.

What is clear from the Circuit decisions in the *Cruz* and *McVeigh* cases is that if the insurance carrier provides proof of an actual conflict between federal and state law (as it did in *Cruz*), the court will find federal question jurisdiction under the *Boyle* test, as enunciated by this Court. Conversely, if the insurance carrier fails to present any proof of any such conflict (as Empire failed to do in *McVeigh*), then the second prong of the *Boyle* test is not met.

Contrary to the position taken by the United States in its Amicus Curiae Brief and contrary to the position taken by Empire, there is no real conflict between the Circuit decisions, only differing results based upon different facts.

As such, there is no compelling reason for discretionary review of these cases by this Court.

CONCLUSION

It is submitted that neither the United States, nor Empire, has presented any evidence or facts to demonstrate any compelling reason for this Court to grant certiorari. Despite the fact that such proof (such as concrete evidence of how state court adjudication of these claims would effect the U.S. Treasury, or effect the uniform administration of the FEHBA program) is clearly in their purview, nothing is presented to justify review by this Court, beyond speculation and conjecture.

Furthermore, neither the United States, nor Empire, shows any substantial conflict among Circuits as to whether or not federal court jurisdiction exists over these types of claims. Both Circuits followed the rule of this Court set forth in Boyle and found jurisdiction when the proof showed an actual conflict between state and federal law.

Respectfully, the Petition should be denied.

Respectfully submitted,

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(13)

Supreme Court, U.S.
FILED
FEB 2 4 2006
OFFICE OF THE CLERK

No. 05-200

IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.
Doing business as Empire Blue Cross Blue Shield,
Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix
of the Estate of Joseph E. McVeigh,
Respondent.

**On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit**

JOINT APPENDIX
VOLUME 1

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Petition for Certiorari Filed August 8, 2005
Certiorari Granted January 6, 2006

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Southern District of New York (Foley Square)
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Date Filed	#	Docket Text
04/18/2003	1	COMPLAINT filed. Summons issued and Notice pursuant to 28 U.S.C. 636(c)
04/18/2003	2	RULE 7.1 CERTIFICATE filed by Empire HealthChoice
04/18/2003	3	EXHIBITS A to B by Empire HealthChoice
04/18/2003	4	EXHIBITS C to J by Empire HealthChoice
04/24/2003	5	AFFIDAVIT OF SERVICE of summons and complaint as to Denise Finn McVeigh by personal service on 4/21/03 . Answer due on 5/12/03 for Denise Finn McVeigh
06/05/2003	7	ANSWER to Complaint by Denise Finn McVeigh
06/06/2003	6	NOTICE OF MOTION by Denise Finn McVeigh to dismiss for lack of jurisdiction purs to FRCP Rule 12(a); purs to FRCP Rule 12(6) dismissing action for failure to state a claim upon which relief can be granted; for summary judgment dismissing plaintiff's complaint; dismissing action because it was not commenced within the applicable Statute of Limitations to assert the claims presented

Date Filed	#	Docket Text
07/03/2003	9	RESPONSE by Empire HealthChoice to defendant's statement of material facts
07/03/2003	10	MEMORANDUM OF LAW by Empire HealthChoice in opposition to motion to dismiss for lack of jurisdiction pursl to FRCP Rule 12(a), motion purs to FRCP Rule 12(6) dismissing action for failure to state a claim upon which relief can be granted, motion for summary judgment dismissing plaintiff's complaint, motion dismissing action because it was not commenced within the applicable Statute of Limitations to assert the claims presented
07/03/2003	11	DECLARATION of Kieran X. Bastible by Empire HealthChoice in opposition to motion to dismiss for lack of jurisdiction purs. to FRCP Rule 12(a), motion purs to FRCP Rule 12(6) dismissing action for failure to state a claim upon which relief can be granted, motion for summary judgment dismissing plaintiff's complaint, motion dismissing action because it was not commenced within the applicable Statute of Limitations to assert the claims presented
07/11/2003	12	REPLY AFFIRMATION of Victor A. Carr by Denise Finn McVeigh Re: opposition memorandum

Date Filed	#	Docket Text
09/18/2003	13	OPINION & ORDER that this breach of contract and declaratory judgment action between private parties does not raise a federal question. The motion to dismiss for lack of subject matter jurisdiction is granted. The Clerk of the Court shall close the case.
09/23/2003	14	JUDGMENT; it is ordered, adjudged and decreed that for the reasons stated in the Court's Opinion and Order, dated 9/18/03, deft's motion to dismiss for lack of subject matter jurisdiction is hereby granted and the case is closed
09/23/2003		Case closed
10/21/2003	15	NOTICE OF APPEAL by Empire HealthChoice
10/21/2003		Notice of appeal and certified copy of docket to USCA
10/28/2003	16	Notice that the record on appeal has been certified and transmitted to the U.S. Court of Appeals

U.S. Court of Appeals for the Second Circuit
Relevant Docket Entries for No. 03-9098

Date Filed	Docket Text
10/22/03	Copy of notice of appeal and district court docket entries on behalf of Appellant Empire HealthChoice filed
12/10/03	Appellant Empire HealthChoice brief FILED with proof of service
12/10/03	Appellant Empire HealthChoice joint appendix filed w/pfs. Number of volumes: 2
12/30/03	Appellee Denise Finn McVeigh brief filed with proof of service
1/20/04	APPELLANT Empire HealthChoice, reply brief filed with proof of service
1/14/05	Judgment of the district court is AFFIRMED by published signed opinion filed
1/14/05	Judge Sack concurs in a separate opinion, filed
1/14/05	Judge Raggi dissents in a separate opinion, filed
1/14/05	Judgment filed
1/28/05	Appellant Empire HealthChoice motion Petition for rehearing filed with proof of service. petition for rehearing en banc filed with proof of service
2/18/05	AMICUS CURIAE U.S. Department of Justice, brief filed with proof of service
3/16/05	Petition Opinion DENYING appellants petition for rehearing FILED
5/10/05	Order FILED DENYING motion petition for rehearing en banc by Appellant Empire HealthChoice, endorsed on motion dated 2/7/2005

Date Filed	Docket Text
5/16/05	Appellant Empire HealthChoice motion stay the mandate filed with proof of service
5/24/05	Order FILED GRANTING motion stay the mandate by Appellant Empire HealthChoice, endorsed on motion dated 5/16/2005
5/25/05	Appellee Denise McVeigh, opposition statement to motion stay the mandate filed with proof of service
8/17/05	Notice of filing petition for APPELLANT Empire HealthChoice, dated 8/10/05 filed. Supreme Court #: 05-200
1/24/06	The Supreme Court has GRANTED the petition for writ of certiorari

105th Congress Report
1st Session House of Representatives 105-374

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

November 4, 1997. -- Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BURTON of Indiana, from the Committee on Government Reform and Oversight, submitted the following

REPORT

[To accompany H.R. 1836]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Reform and Oversight, to whom was referred the bill (H.R. 1836) to amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

* * * * * *

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Health Care Protection Act of 1997".

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) Amendments. -- Section 8902a of title 5, United States Code, is amended --

(1) in subsection (a) --

(A) in paragraph (1) --

(i) by striking "and" at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(iii) by adding at the end the following:

"(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;"; and

(B) in paragraph (2)(A), by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)";

(2) in subsection (b) --

(A) by striking "The Office of Personnel Management may bar" and inserting "The Office of Personnel Management shall bar"; and

(B) by amending paragraph (5) to read as follows:

"(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).";

(3) by redesignating subsections (c) through (d) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

"(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

"(1) Any provider --

"(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the providers professional competence, professional performance, or financial integrity; or

"(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the providers professional competence, professional performance, or financial integrity.

"(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

"(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

"(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such

charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

"(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.";

"(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows:

"(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves --

"(A) an item or service not provided as claimed,

"(B) charges in violation of applicable charge limitations under section 8904(b), or

"(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);";

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after "under this section" the first place it appears the following: "(where such debarment is not mandatory)";

(6) in subsection (g) (as so redesignated by paragraph (3)) --

(A) by striking "(g)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

"(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).";

(B) in paragraph (3) --

(i) by inserting "of debarment" after "notice"; and

(ii) by adding at the end the following: "In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).";

(C) in paragraph (4)(B)(i)(I) by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)"; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking "(h)(1)" and all that follows through the end of paragraph (2) and inserting the following:

"(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

"(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support

the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion."; and

(8) in subsection (i) (as so redesignated by paragraph (3)) --

(A) by striking "subsection (c)" and inserting "subsection (d)"; and

(B) by adding at the end the following: "The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.".

(b) Effective Date. --

(1) IN GENERAL. -- Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS. -- (A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments

based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER. -- Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking "organization;" and inserting "organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;".

(b) SERVICE BENEFIT PLAN. -- Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking "plan," and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States,".

(c) PREEMPTION. -- Section 8902(m) of title 5, United States Code, is amended by striking "(m)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.".

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN. For purposes of chapter 89 of title 5, United States Code, any period of enrollment --

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to

which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE. -- (1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual --

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, annuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN. -- Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND. -- The Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of

Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(c) ADMINISTRATION AND REGULATIONS. -- The Office of Personnel Management --

(1) shall administer the provisions of this section to provide for --

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT. --

(1) IN GENERAL. -- Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

" 8903b. Authority to readmit an employee organization plan

"(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plans eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

"(b) A contract for a plan approved under this section shall require the carrier --

"(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

"(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.".

(2) CONFORMING AMENDMENT. -- The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

"8903b. Authority to readmit an employee organization plan.".

(3) APPLICABILITY. --

(A) IN GENERAL. -- The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE. -- For purposes of applying section 8903b(a) of title 5, United States Code (as

amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting "second contract year" for "third contract year".

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN. --

(1) IN GENERAL. -- Subsection (e) of section 8909 of title 5, United States Code, is amended by striking "(e)" and inserting "(e)(1)" and by adding at the end the following:

"(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

"(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.".

(2) TRANSITION RULE. -- In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accordance with section 8909(e) of title 5, United States Code, as amended by this subsection, by --

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL. -- Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking "$20,000" and inserting "$30,000".

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS. --

(1) IN GENERAL. -- Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION. -- A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of such title (as amended by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION. -- Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended --

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

"(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.".

I. SUMMARY OF LEGISLATION

H.R. 1836, as amended by the Committee, amends several provisions in title 5, United States Code. It provides the Office of Personnel Management (OPM) additional tools to fight waste, fraud, and abuse in the Federal Employees Health Benefits (FEHB) program. With these tools, OPM will be able to deal swiftly with health care providers who try to defraud the FEHB program. OPM will be better equipped to bar health care providers who engage in misconduct from participating in the FEHB program or to impose monetary penalties on them. The bill also provides that an association of organizations may underwrite health care plans in the FEHB program, and it broadens the current statutory language preempting State insurance laws.

In addition, the bill permits certain employees of the Federal Deposit Insurance Corporation (FDIC) and the Federal Reserve Board (Fed) to participate in the FEHB program, and it requires OPM to encourage carriers who contract with third parties to obtain discounts from health care providers to seek assurances that the conditions for the discounts are fully disclosed to such providers. It also establishes statutory requirements for readmitting health care plans sponsored by employee organizations that have previously discontinued participation in the FEHB program. Under current law, when a health care plan discontinues participation in the FEHB program, OPM must credit that plans remaining contingency reserves to those plans that remained in the FEHB program in the contract year after the discontinuance. This bill requires OPM to complete the distribution by the end of the second contract year after the plan is discontinued.

The maximum amount of the physicians comparability allowance under 5 U.S.C. § 5948 is increased from $20,000 to $30,000.

The bill also amends 5 U.S.C. § 8902(k) to explicitly permit carriers to provide for direct access and direct

payments to licensed health care providers who are not currently enumerated in the statute.

II. Background and Need for the Legislation

Section 1

H.R. 1836 was introduced by Mr. Burton of Indiana to strengthen the integrity and standards of the FEHB program and allow it to maintain its reputation as a high quality and cost-effective program. The FEHB program is the largest employer-sponsored health insurance system in the country. In 1997, the $16 billion FEHB program will insure more than nine million Federal employees, retirees, and their dependents. Partial portability, the absence of preexisting condition limitations, and an annual open enrollment period are facets of the FEHB program that make it an extremely attractive health care system. The programs market orientation has effectively contained costs through private sector competition with limited governmental intervention. The program is often cited as a model of efficiency and effectiveness that the private sector and the public sector should attempt to replicate. This bill will improve the program and its performance without changing the market principles that are the key to its success.

Section 2

Section 2 of this bill addresses the debarment of health care providers engaging in fraudulent practices. This provision would strengthen the ability of OPM to bar health care providers who engage in professional and or financial misconduct from participating in the FEHB program or to impose monetary penalties on them. Under this bill, the administrative sanctions authority would conform more closely with provisions of Medicare law. The parallels between these provisions and Medicare law should benefit not only OPM, but also carriers and health care providers, who are already familiar with interpretations and practices under similar Medicare provisions.

In addition, this bill streamlines the debarment process by generally permitting OPM to debar a provider before a hearing is held. However, upon request, the provider would be entitled to an administrative hearing after an adverse determination is made if the provider shows that due process rights were not previously afforded with respect to any finding of fact which is relied upon as a cause for the adverse determination. The hearing will be held before a hearing officer who shall be designated by the Director of OPM and conducted without regard to the requirements of subchapter II of chapter 5 and chapter 7 of title 5, United States Code. Judicial review shall lie with the United States District Court for the District of Columbia or other appropriate district, rather than, as under current law, with the United States Court of Appeals for the Federal Circuit.

Under current law, OPM is permitted to debar health care providers on certain grounds, but it is not required to do so. This bill makes debarment mandatory if a health care provider is convicted of certain criminal offenses or is currently debarred, suspended or otherwise excluded from any procurement or nonprocurement activity within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994.

OPM retains its existing authority to debar health care providers on grounds relating to professional licensing, and this bill adds four additional grounds for permissive debarment, including the determination that a provider has charged substantially more than the providers customary charge for health care services or supplies without good cause, or has charged for substandard or medically unnecessary health care services or supplies. The determination that a service or supply is medically unnecessary must be made by trained reviewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. These trained reviewers may be employees of

OPM, other appropriately trained Federal employees, or contractors.

Existing law does not mandate a minimum period of debarment. This bill, however, requires that providers convicted under Federal or State law of certain offense must be debarred for at least 3 years.

Under current law, OPM, in consultation with the Attorney General, may impose a civil monetary penalty of up to $10,000 on a health care provider guilty of certain misconduct. This bill modifies the grounds upon which OPM may assess such penalties. OPM's authority to impose a monetary penalty on health care providers for excessive charges or charges for substandard or medically unnecessary services or supplies is deleted. (That misconduct becomes, instead, grounds for permissive debarment.) But it is given additional authority to impose a civil penalty for charges exceeding Medicare limitations in violation of 5 U.S.C. § 8904(b) or charging for items or services provided during a period of debarment.

These modifications of OPM's authority to debar health care providers and impose monetary penalties upon them will strengthen OPM's ability to protect the FEHB program -- and the employees and retirees who depend upon it -- from fraudulent or abusive practices that drive up health care costs and premiums.

Section 3

The bill amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. The revised definition makes clear that an association of organizations, or other entities, may be the carrier for any health benefits plan in the FEHB program. The new description makes clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. Indeed, although the government-wide Service Benefit Plan historically has been underwritten by all of the affiliates of the sponsoring association, the

withdrawal of an affiliate in a State would not affect the sponsoring associations ability to continue offering the plan in that State.

In addition, this bill broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live. This change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts. It will also prevent carriers cost-cutting initiatives from being frustrated by State laws. For example, a carrier's effort to establish a preferred provider organization (PPO) across the country would not be jeopardized by State-mandated "any willing provider" statutes.

* * * * * * *

V. EXPLANATION OF THE BILL AS REPORTED SECTION-BY-SECTION

* * * * * * *

Subsection (a)(7) amends provisions relating to the notice and hearing requirements and to judicial review. Under current law, OPM may not debar a provider or impose a monetary penalty until after the provider has been given written notice and an opportunity for a hearing on the record, and any person affected by OPM's final adverse decision may obtain review in the United States Court of Appeals for the Federal Circuit. This subsection provides that a provider subject to an adverse determination by OPM is entitled to reasonable notice and an opportunity to request a hearing of record. OPM is required to grant a request for a hearing upon a showing that due process rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination. The hearing is not subject to subchapter II of chapter 5 or chapter 7 of title 5, which relate to administrative procedures and judicial review. Judicial review is available in the United States District Court for the District of Columbia, or for the district in which the plaintiff

resides or has his or her principal place of business. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record, taken as a whole, to support the findings by OPM or unless OPM has abused its discretion.

* * * * * * *

XVI. CHANGES IN EXISTING LAW

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in the existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

* * * * * * *

Subsection (c) amends section 8902(m) to broaden the preemption of State and local laws with respect to health care contracts under the FEHB program. This amendment confirms the intent of Congress (1) that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) completely displace State or local law relating to health insurance or plans and (2) that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, including managed care programs.

* * * * * * *

§ 8902. Contracting authority

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health

insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * * *

§ 8902a. Debarment and other sanctions

* * * * * * * *

(h)(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

[IMAGE]

December 17, 1999

WHITMAN BREED ABBOTT & MORGAN LLP
200 Park Avenue
New York, New York 10166

Attention: David M. Berger

RE: Our client: JOSEPH McVEIGH, DENISE McVEIGH
Your client: EMPIRE BLUE CROSS/BLUE SHIELD

Dear Mr. Berger:

I am writing in response to your letter of November 17, 1999 regarding the right of subrogation of your client for medical payments. Please excuse my delay in responding.

Enclosed is a copy of the Summons & Verified Complaint in our action. Also enclosed is a copy of a recent motion so that you can see the present status of the two consolidated cases. The motion also provides the attorneys representing all parties in these cases and court information.

While we certainly understand EBCBS's right of subrogation and are providing information in an effort to cooperate with you and EBCBS in this regard, it is our understanding of the current law that such right of

subrogation does not constitute a lien against a recovery in a personal injury case as you state in your letter.

If you have some authority for the assertion of a lien, I would ask that you provide such authority so that it can be reviewed and our file properly documented.

The personal injury case is still pending in Supreme Court, Suffolk County and should be next scheduled with Justice Bromley Hall for a compliance/certification conference.

Very truly yours,

/s/
VICTOR A. CARR

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

----------x

JOSEPH FINN and PATRICIA FINN,

Plaintiffs,

- against -

Index No.
11335/98

TOWN OF SOUTHAMPTON, GREGORY G. L'HOMMEDIEU and CHRIS G. L'HOMMEDIEU,

Defendants.

----------x

DENISE FINN McVEIGH, As Administratrix of the Estate of JOSEPH E. McVEIGH, deceased, and DENISE FINN McVEIGH, Individually,

Plaintiff,

- against -

TOWN OF SOUTHAMPTON, GREGORY G. L'HOMMEDIEU, CHRIS G. L'HOMMEDIEU, MERCEDES-BENZ CREDIT CORPORATION, and JOSEPH FINN,

Defendants.

----------x

TOWN OF SOUTHAMPTON,

Third-Party Plaintiff,

- against -

Index No.
22/233

ROY CLARK INVESTIGATION & SECURITY SERVICE, LTD.,

Third-Party Defendant.

----------x

MERCEDES-BENZ CREDIT CORPORATION,

Second/Third Party Plaintiff,

- against -

Index No.
22/275

ROY CLARK INVESTIGATION & SECURITY SERVICE, LTD.

Second/Third Party Defendant.

----------x

March 19, 2003
Riverhead, New York

Before:

HON. EDWARD D. BURKE, Justice.

Appearances: [omitted for printing]

William J. Fugelsang, C.S.R.
Official Court Reporter

MR. STOCK: Would you swear in the plaintiffs, please.

JOSEPH J. FINN, a plaintiff herein, of 52 Argonne Road East, Hampton Bays, New York, being duly sworn, testified as follows:

EXAMINATION BY

MR. DOWNES:

Q Joe, you understand that there is a settlement offer in the claim brought by yourself and your wife with respect to the action against the Town of Southampton, Chris L'Hommedieu and Greg L'Hommedieu, is that correct?

A Yes.

Q And you understand, having spoken with myself and my office, that there has been a gross settlement offer of $275,000 in this matter?

A Correct.

Q And of that settlement the L'Hommedieu defendants, and/or their carrier, are going to pay the sum of $250,000, and on behalf of the town of Southampton a payment of $25,000 is going to be made, do you understand?

A Yes.

Q Do you understand that by giving your consent to the settlement of this action today, this cause of action arising out of the automobile accident of May 19, 1997 will be closed, and you cannot come back to court with respect to the injuries as a result of this particular accident?

A I understand.

Q And you have had an opportunity to speak with your wife, Frances, regarding this proposed settlement, right?

A Yes.

Q And, of course, she is also a party to this action, correct?

A Yes.

Q And at the present time do you speak with the consent of Frances with respect to this settlement?

A Yes.

Q And is it your desire to accept the settlement offer that has been proposed in this action, that is, the payment of the $275,000?

A Yes.

Q And do you also understand that out of that gross settlement of $275,000 there are attorneys' fees that must be satisfied, and disbursements associated with the prosecution of this case?

A Yes, I understand.

Q And is it your desire to accept the settlement that has been proposed in this action?

A Yes, I do.

Q And, of course, on behalf of your wife you are accepting this of your own fee [sic] will, is that correct?

A Yes.

Q Do you also understand that we have to sign general releases and a stipulation of discontinuance and serve that upon the attorneys for the respective defendants in this particular action?

A Yes.

Q And upon receipt of those papers they will make payment to you, do you understand that?

A Right.

MR. DOWNES: It is hereby stipulated by and between the attorney for the respective parties herein that this action, specifically the action of Joseph Finn and Frances Finn against the Town of Southampton, Gregory G. L'Hommedieu and Chris G. L'Hommedieu, is hereby settled in the sum of $275,000, and upon payment of such consideration the action will be discontinued with prejudice, and without further costs to any party.

It is also my understanding that upon receipt of proper release papers and stipulations of discontinuance, on behalf of the defendants L'Hommedieu payment will be made within 60 days time, and with respect to the Town of Southampton payment will be made on or before the expiration of 90 days.

THE COURT: Mr. Finn, have you had ample time to discuss this matter in full with your attorney?

MR. FINN: Yes, sir.

THE COURT: And you are satisfied with the services rendered by your attorneys?

MR. FINN: Yes.

THE COURT: And you understand that you can't come back to court on this claim after this settlement?

MR. FINN: I understand.

THE COURT: All right.

MR. STOCK: Off the record a minute.

(Off-record discussion.)

MR. STOCK: It is hereby stipulated and agreed by and between counsel for the plaintiff and the defendants in action number two, entitled Denise Finn McVeigh, as Administratrix of the Estate of Joseph McVeigh, deceased, and Denise Finn McVeigh, plaintiffs, against the Town of Southampton, et al, that that action is settled for the total sum of 3,175,000.

The One Beacon Insurance Company, on behalf of Joseph Finn, will pay within 30 days after presentation to their counsel, Renny Way, of a wrongful death compromise order, and a general release from all of the plaintiffs, as well as stipulations of discontinuance, the sum of $1,500,000.

The defendant Mercedes-Benz Credit Corporation will, upon presentation to their counsel, Lester, Schwab,

Katz and Dwyer of a wrongful death compromise order, general releases and stipulations of discontinuance, pay within 30 days the sum of $1,100,000, which will be structured to some extent.

The defendant Gregory G. L'Hommedieu and/or the One Beacon Insurance Company, on behalf of the defendants Gregory G. L'Hommedieu and Chris G. L'Hommedieu, will pay the sum of $232,000 upon presentation to counsel-

MR. ALEDORT: Wait, that's not correct. Off the record.

(Off-record discussion.)

MR. STOCK: The insurers for Gregory G. L'Hommedieu and Chris G. L'Hommedieu will pay on their behalf, upon presentation to their attorneys, Scibillia, Polacco and Aledort of a wrongful death compromise order, general releases and stipulations of discontinuance, within 30 days, the sum of $325,000.

The defendant Town of Southampton will pay the sum of $250,000 upon presentation of a wrongful death compromise order, general releases and stipulations of discontinuance to their counsel, Kelly Rode and Kelly, within 30 days.

The defendant and Third-Party plaintiff Town of Southampton and Mercedes-Benz Credit Corporation, shall provide the Third-Party defendant Roy Clark Investigation and Security Service, Ltd. with a general release and stipulations of discontinuance, with prejudice.

As everyone knows, there are four causes of action involved in this case: a claim for personal injury by Denise Finn, a claim for loss of consortium by Denise Finn, a claim on behalf of the Estate of Joseph McVeigh for pain and suffering, and a wrongful death claim on behalf of his distributees.

The plaintiffs reserve the right, subject to the Surrogate of New York County, to assign to those particular causes of action that portion of the total settlement that it deems proper, and the Surrogate approves.

The defendants have indicated, and indicate herein, that they have no interest in that, and consent to however that is distributed.

The plaintiff herein agrees and represents to defendants that there are no liens on the recovery in this action, and that in the event that any liens should appear, the plaintiff will indemnify the defendants and defendants' counsel from any claims by by [sic] any lien holder not known to us.

The plaintiffs also represents that they are aware that there is a claim of lien by Empire Blue Cross/Blue Shield of $175,000 approximately, and we dispute that lien. You have been advised of that.

We have agreed with counsel for the alleged lien holder to hold in escrow the sum of $100,000 until there is a resolution of that lien holder's claim. The lien holder is present and joins in this stipulation, and agrees that they will bring any claim that they intend to bring within thirty days of this stipulation or be time barred from doing so.

The plaintiff reserves to itself the right to bring an Order to Show Cause in this court to have this court resolve that issue should it deem that to be in its best interests. The alleged lien holder and myself disagree on whether that's appropriate in terms of the jurisdiction of this court, and we agree that the courts will have to decide that as being an open issue.

We further agree that the extent of the lien holder's lien, if any, is still in issue, and that they are not waiving any portion of their claim at this time, they are merely

agreeing that they will not bring any claim against anyone else involved in this case to assert their lien, other than the estate of Joseph McVeigh.

The third-party action an [sic] cross claims are as well discontinued without interest, costs or disbursements to any party.

The settlement that we have placed upon the record is subject to the approval of the Surrogate of New York County in the submission of the wrongrul [sic] death compromise order.

Off the record.

(Off-record discussion)

MR STOCK: The Surrogate of New York County has jurisdiction and will have to approve the wrongful death in the survivor's action. He has no jurisdiction to hear or approve Denise Finn's personal injury action or her claim for loss of consortium.

In addition, the general release that we provide to Mercedes-Benz Corporation will also release Allion Insurance Corporation.

Mr. Bastible is present on behalf of Morrison, Cohen, Singer and Weinstein, LLP, and, sir, do you agree to the terms of the stipulation as it applies to your claim of lien, and you have authority to do so?

MR. BASTIBLE: I do have authority and I do stipulate, having in mind though the issue as to which court may have proper jurisdiction.

MR. STOCK: But as to the remainder of the stipulation you agree?

MR. BASTIBLE: Yes, I do.

MR. STOCK: And Mr. Bastible's firm has written letters to all the law firms involved in the case indicating that they intended to bring claims against those law firms

and their clients in the event that the lien was not paid, or this alleged lien was not paid today.

Counsel, you withdraw that, I assume, and agree that you are not going to bring a claim against any of the other parties involved in this case, other than the estate of Joseph McVeigh, or my office as the escrow holder?

MR. BASTIBLE: Certainly not, no.

MR. DORRY: None of the defendants or their law firms?

MR. BASTIBLE: That is correct.

MR. STOCK: And with respect to the settlement from Allion Insurance, on behalf of the Mercedes-Benz Credit Corporation, the plaintiffs herein are agreeing to structure that portion of that settlement which is going to be distributed, again subject to the approval of the Surrogate as to the decedent infant Brendan McVeigh, at least that amount.

I have nothing further.

MR. DORRY: With respect to the third-party plaintiff Mercedes-Benz Credit Corporation against Roy Clark, I have spoken with them and we are just going to send a stipulation of discontinuance with prejudice.

MR. STOCK: Now Denise, you have heard the stipulation of settlement as put on the record, is that correct?

DENISE FINN MC VEIGH: Yes, I have.

MR. STOCK: And we have had an opportunity over the last week or so to discuss the settlement that we are talking about and that you have heard put on the record?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And are you satisfied with the settlement?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you understand it?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you have had time to talk to me about it, and I have explained it all to you?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you understand that once we agree to settle this today, and the Surrogate approves the settlement, that we can never come back to court for the injuries that occurred to Joe or yourself as the result of the accident that took place on May 9, 1997?

DENISE FINN MC VEIGH: I understand.

MR. STOCK: And knowing all of that you are agreeable to the settlement?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you understand that out of the settlement sum will come the fees and disbursements, attorney's fees and disbursements?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: I have nothing further.

MR. HOEFLING: On behalf of Joe Finn there was a representation that there are no liens, but if there are, we are being held harmless, our law firms and our clients and our carriers? I didn't hear that, so I would seek to add that to the stipulation.

THE COURT: Is that so stipulated on behalf of the plaintiff?

MR. DOWNES: As counsel for Joe Finn, my understanding is that there are none; I have not been informed of any liens relative to the claim brought by Mr. Finn with respect to medical or anything.

If there are claims for liens or medical services, plaintiffs will hold the defendants and their counsel harmless with respect to such claims.

MR. STOCK: So stipulated?

MR. DOWNES: So stipulated.

MR. AALVARADO: So stipulated.

MR. DORRY: So stipulated.

MR. WAY: So stipulated.

MR. HOEFLING: So stipulated.

MR. ALDORT: So stipulated.

THE COURT: Submit your papers, counsel.

MR. STOCK: And thank you for your assistance, your Honor.

(The matter thereupon concluded.)

- - -

CERTIFICATION is given that the foregoing is a true and complete transcript of the stipulation of settlement as placed upon the record in the within matter.

/s/

Official Court Reporter

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC.
d/b/a/ Empire Blue Cross Blue Shield,

Plaintiff,

v.

DENISE FINN MCVEIGH, as Administratrix of the Estate of Joseph E. McVeigh,

Defendant.

COMPLAINT
(Civil Action No. 03CV2728)

Plaintiff Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross Blue Shield ("Empire") brings this complaint against Defendant Denise Finn McVeigh, administratrix of the estate of Joseph E. McVeigh, and respectfully states as follows:

NATURE OF ACTION

1. Joseph E. McVeigh ("Decedent") was enrolled in the Service Benefit Plan, one of the federal government's nation-wide health benefits plans for federal employees and their dependents. The Service Benefit Plan was created by federal government contract between the United States Office of Personnel Management ("OPM") and the Blue Cross and Blue Shield Association ("BCBSA"), pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C.

§§ 8901-8914. Empire is the Blue Cross and Blue Shield entity that administers the Service Benefit Plan in New York

2. Empire seeks to recover benefits it paid to the Decedent for the treatment of injuries sustained by the Decedent, because the Decedent's estate, administered by Defendant Denise Finn McVeigh, has made a recovery on his behalf in connection with those injuries through settlement with alleged third-party tortfeasors. Plaintiff is entitled to reimbursement under the unambiguous terms of the Service Benefit Plan's subrogation and right-of-recovery provisions. Accordingly, Empire brings this action to enforce the terms of one of the federal government's health benefits plans and to obtain the relief that those terms warrant.

3. The money originally paid by Empire for Decedent's benefits came from premiums collected by OPM for enrollment in the Service Benefit Plan. The U.S. government contributes the majority of these funds, which are held in the federal Treasury. The recovery that Plaintiff makes in this case will inure to the benefit of the United States because it will result in the return to the U.S. Treasury of money earlier expended by the United States on benefits. Accordingly, Plaintiff's recovery in this case directly affects the United States' interests. Under BCBSA's contract with OPM, Plaintiff has an obligation to seek reimbursement of the federal government's funds where the enrollee has recovered from a third party.

JURISDICTION

4. This action is founded on the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914; on federal contracts and regulations established pursuant to FEHBA; and on federal common law. It involves the Service Benefit Plan, a health benefits plan established pursuant to FEHBA. Plaintiff's cause of action for reimbursement turns on the construction and application of FEHBA, federal contract provisions, federal regulations, and

federal common law. This Court, therefore, has jurisdiction over this action pursuant to 28 U.S.C. § 1331.

VENUE

5. Venue lies in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

PARTIES

6. FEHBA gives OPM the responsibility for establishing and regulating federal health benefits plans for federal employees and their dependents. Pursuant to this statutory mandate, OPM entered a federal government contract with BCBSA to establish the Service Benefit Plan. See generally 1996 Contract between OPM and the Association and subsequent amendments (Exh. A); 2002 Contract between OPM and the Association (Exh. B). The Service Benefit Plan is underwritten by local Blue Cross and Blue Shield companies, which administer the Service Benefit Plan in their localities. Empire is the local Blue Cross and Blue Shield company that administers the Service Benefit Plan in New York.

7. Defendant Denise Finn McVeigh is administratrix of the Decedent's estate; at all times relevant to this action, the Decedent was enrolled in the Service Benefit Plan. The estate has its situs in this District and Ms. McVeigh resides in this District.

FACTS

8. Upon information and belief, the Decedent suffered injuries in 1997 for which he received medical treatment.

9. Beginning in 1997, the Decedent and his health care providers submitted numerous claims to Empire for coverage of medical treatment relating to Decedent's injuries.

10. Between 1997 and 2001, Empire paid $157,309.06 in benefits for medical treatment relating to Decedent's injuries. This represents the amount of benefits to which the

Decedent was entitled under the terms of the Service Benefit Plan.

11. Upon information and belief, Decedent died on November 9, 2001 from his injuries.

12. In addition to Decedent's claims for benefits from Empire, Defendant Denise Finn McVeigh filed a tort action in state court on the Decedent's behalf and on her own behalf against the third parties that allegedly caused the Decedent's injuries. The minor child of the Decedent and Ms. McVeigh also filed an action in state court on the minor child's behalf against the third parties.

12. The Service Benefit Plan contains a subrogation and right-of-recovery provision. Pursuant to the Service Benefit Plan, if the local administering Blue Cross and Blue Shield company pays benefits to an enrollee for treatment necessitated by an injury and the enrollee later recovers compensation from a third party in connection with that injury, then the enrollee must reimburse the local administering Blue Cross and Blue Shield company, in this case Empire, for the amount of benefits paid. The subrogation and right-of-recovery provision provides:

> This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.
>
> If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to

exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any

> recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

1997 Statement of Benefits for the Service Benefit Plan at 12 (Exh. C); accord 1998 Statement of Benefits for the Service Benefit Plan at 12 (Exhibit D); 1999 Statement of Benefits for the Service Benefit Plan at 12 (Exh. E); 2000 Statement of Benefits for the Service Benefit Plan at 12 (Exh. F); 2001 Statement of Benefits for the Service Benefit Plan at 86 (Exh. G).

14. In March 2003, Empire learned that Ms. McVeigh had agreed to settle her claims on behalf of the Decedent and herself against the alleged tortfeasors. On March 11, 2003 Empire notified her, through her counsel Defendant Thomas J. Stock, that it had a lien against the estate's portion of the tort settlement in the amount of $157,309.06. *See* Letter from Howard F. Wolfson to Thomas J. Stock at 2 (Mar. 11, 2003) (Exh. H).

15. Defendant responded by disputing the existence of Empire's lien. *See* Letter Thomas J. Stock to Howard S. Wolfson (Mar. 13, 2003) (Exh. I). Mr. Stock has also stated that Empire "never has and never will have a lien on the recovery in [the tort] action." Letter from Thomas J. Stock to Alfredo J. Alvarado at 1 (Mar. 7, 2003) (Exh. J).

16. In a hearing conducted March 19, 2003 in connection with the settlement, Ms. McVeigh and the other parties to the tort actions stipulated to settlement for the sum total of $3,175,000 for both the suit brought by her on the estate's behalf and individually and the suit brought by her minor child, with the respective shares for each claimant imminently to be determined.

17. At the hearing, in light of the disagreement between them and Empire, Ms. McVeigh, through her counsel, agreed

to hold $100,000 of the settlement funds in escrow pending resolution of Empire's claims for enforcement of its lien. The escrowing of that amount was not to be in prejudice of Empire's right to recover the full amount of $157,309.06 to which it is entitled. Empire agreed that it would file a lawsuit to resolve its right to reimbursement within thirty days from the date of the settlement hearing.

COUNT I
(Breach of Obligations under FEHBA Plan)

18. Plaintiff repeats and re-alleges paragraphs 1-17 as if fully set forth herein.

19. Defendant's refusal to reimburse Empire from the settlement proceeds for the amount of benefits paid by Empire violates the express terms of the Service Benefit Plan. Under the provisions of the Service Benefit Plan, Defendant -- on the estate's behalf -- is obligated to reimburse Empire for the full amount of benefits the Decedent received, upon the estate's recovery from the third parties associated with Decedent's injuries. Defendant has flatly rejected Empire's assertion of a lien and refused to pay back any amounts the Decedent received in benefits. Accordingly, Defendant has breached and imminently will further breach obligations under the Service Benefit Plan, and Plaintiff is entitled to relief.

COUNT II
(Declaratory Judgment)

20. Plaintiff repeats and re-alleges paragraphs 1-19 as if fully set forth herein.

21. Empire has asked Defendant for reimbursement from the settlement proceeds for the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries.

22. Despite Empire's demand, Defendant has refused to reimburse Empire for the amount of benefits paid by Empire

on behalf of the Decedent for treatment of the Decedent's injuries.

23. As a result, an actual and justiciable controversy has arisen between Empire and Defendant as to whether Empire had and continues to have the right to reimbursement of the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries, pursuant to the express terms of the Service Benefit Plan.

24. Empire is entitled to a judgment declaring that, pursuant to the express terms of the Service Benefit Plan, as well as FEHBA, its implementing federal regulations, and federal common law, it has the right to reimbursement from Defendant for the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court:

A. Declare that Empire has a lien in the amount of $157,309.06 against the settlement proceeds of Defendant Denise Finn McVeigh relating to her state court claim on behalf of Decedent's estate against the third parties alleged to have caused Decedent's injuries;

B. Enter judgment against Defendant Denise Finn McVeigh, as administratrix of the Decedent's estate, in the amount of $157,309.06 to reimburse Empire for benefits paid for medical care relating to Decedent's injuries;

C. Order Defendant to disburse to Empire the amount of $100,000 currently escrowed for the purpose of protecting Empire's lien, as partial reimbursement for the benefits Empire paid to the Decedent;

D. Order Defendant to pay Empire an additional amount of $57,309.06 upon receipt of said amount in the settlement of Defendant Denise Finn McVeigh's state court

claim on the estate's behalf against the third parties alleged to have caused Decedent's injuries;

E. Grant such other and further relief as this Court deems necessary and proper.

Respectfully submitted,

EMPIRE BLUE CROSS & BLUE SHIELD,

By: /s/_____

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC.
d/b/a/ Empire Blue Cross Blue Shield,

Plaintiff,

v.

DENISE FINN MCVEIGH, as Administratrix of the Estate of Joseph E. McVeigh,

Defendant.

DECLARATION OF CLINTON SHATZER
(Civil Action No. 03CV2728(DJC))

CLINTON SHATZER, declares the following to be true under penalties of perjury:

1. I am the Senior Program Manager, Financial Policy for the Blue Cross and Blue Shield Association ("BCBSA") Federal Employee Program. I have held this position for approximately two years. I have been employed by BCBSA for 19 years.

2. BCBSA, a nonprofit membership organization, owns and licenses the Blue Cross and Blue Shield service names and service marks. Forty-three individual Blue Cross and Blue Shield companies nationwide are its members. They offer

health care benefits throughout the United States and administer the payment of health benefits claims.

3. BCBSA, on behalf of participating Blue Cross and Blue Shield companies, has entered into a contract with the U.S. Office of Personnel Management ("OPM"), to offer the Government-wide Service Benefit Plan ("Service Benefit Plan") to federal employees and annuitants. Under that contract, the local Blue Cross and Blue Shield companies administer benefits for and underwrite the Service Benefit Plan in their individual localities.

4. Service Benefit Plan premiums are paid by the government and federal employees and retirees according to a formula set forth in the Federal Employees Health Benefits Act. The government typically pays approximately 72% of the premium, with the federal employees and retirees paying the remainder. The premiums are collected by the federal payroll offices and forwarded to a specially-created fund in the U.S. Treasury called the Employees Health Benefits Fund.

5. Blue Cross and Blue Shield companies pay health care providers and enrollees for services covered by the Service Benefit Plan. They are in turn then paid from Service Benefit Plan premiums using a special Letter of Credit Account ("LOCA") set up in the U.S. Treasury.

6. Premium payments collected for the Service Benefit Plan are made available in the LOCA for withdrawal by the Blue Cross and Blue Shield companies. They withdraw funds from the LOCA on a "checks-presented basis." This means that their withdrawals are delayed until the checks they have issued for FEHBA Program disbursements are presented to their banks for payment.

7. Each Blue Cross and Blue Shield company returns subrogation and reimbursement funds to the Employees Health Benefits Fund in the U.S. Treasury by reducing their LOCA withdrawals. For example, assume that a Blue Cross and Blue Shield company has $100,000 in checks presented

to its bank for payment from providers, and so is entitled to draw down $100,000 from the Service Benefit Plan's LOCA in the Federal Treasury. It also, however, has $10,000 in subrogation or reimbursement recoveries that it needs to return to the Federal Treasury account. In such a case, it would drawn [sic] down $90,000, thus effectively returning the $10,000 in subrogation or reimbursement funds to the LOCA.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 19, 2003.

/s/
Clinton Shatzer

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,	)	
Plaintiff,	)	
v.	)	Civil Action No. 03-CV-2728 (DC)
DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH,	)	
Defendant.	)	

EMPIRE'S RESPONSE TO DEFENDANT'S STATEMENT OF MATERIAL FACTS

In response to Defendant's Statement of Material Facts, Plaintiff Empire HealthChoice Assurance, Inc., d/b/a Empire Blue Cross Blue Shield ("Empire") does not dispute paragraphs 1-3. Empire does not admit the statement in paragraph 4, but notes that it lacks sufficient knowledge regarding the statement either to admit or dispute it. In any event, none of the alleged facts stated by Defendant as material and undisputed supports either dismissal or summary judgment in Defendant's favor in this case.

Respectfully submitted,

EMPIRE BLUE CROSS &
BLUE SHIELD

By: /s/_____

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[Affidavit of Service omitted for printing.]

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,	)	
Plaintiff,	)	
v.	)	Civil Action No. 03-CV-2728 (DC)
DENISE FINN McVEIGH, as Administratrix of the Estate Of JOSEPH E. McVEIGH,	)	
Defendant.	)	

PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND FOR SUMMARY JUDGMENT

Plaintiff Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross Blue Shield ("Empire") respectfully files this memorandum in opposition to Defendant's motion to dismiss and Defendant's motion for summary judgment.

INTRODUCTION & SUMMARY

This case involves a dispute between Empire and the estate of Joseph E. McVeigh over whether the estate has a duty to reimburse Empire for health benefits Empire paid to or on behalf of Mr. McVeigh. Mr. McVeigh was injured in an accident in 1997, and Empire paid benefits in connection with those injuries. After Mr. McVeigh's death, Defendant Denise Finn McVeigh, the administratrix of Mr. McVeigh's estate, sued in New York State Supreme Court the parties that allegedly caused Mr. McVeigh's injuries. In the same

action, she also sued the alleged tortfeasors in her individual capacity, as did Mr. McVeigh's minor child. On March 19, 2003, Defendant reported to the state court that all parties had agreed to settle all claims in the case for a collective recovery of approximately $3 million. She also reported that Empire claimed a lien on the settlement based on the benefits it had earlier paid; that the estate and Empire had reached an impasse over Empire's entitlement to those funds; that $100,000 had been escrowed to cover part of that lien; and that Empire and the estate had stipulated that Empire would file a claim within 30 days of the hearing to resolve the lien dispute. Additionally, because the settlement involved a minor, Defendant stated that the New York State Surrogate's Court had to approve the terms of the settlement. Defendant maintains that the Surrogate's Court has not yet approved the settlement.

Consistent with the stipulation of the parties, Empire filed this lawsuit against Defendant, as administratrix of the estate, seeking declaratory and other relief to resolve the lien controversy. The complaint raises two counts: one for breach of the terms of the health benefits plan and one for a declaratory judgment that Empire has a lien or subrogation rights. Defendant now moves to dismiss the complaint, raising essentially four arguments: (1) that the Court lacks federal question jurisdiction; (2) that the Court should dismiss the case because it involves an estate subject to probate in the state courts; (3) that the Court should abstain from exercising jurisdiction; and (4) that the case is premature. The estate also moves for summary judgment, contending that the case is barred by a state-law statute of limitations, notwithstanding that Defendant otherwise asserts that this suit is, at the same time, premature.

The Court should deny the motion to dismiss. First, the Court has federal question jurisdiction. Mr. McVeigh was enrolled in one of the federal government's health benefits plans for federal employees, and it is that health benefits plan that Empire here asserts was breached. The

plan is established through federal government contract pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901-8914; moreover, cases involving the plan's interpretation are controlled by federal common law, most notably because it is the federal government's own money that is at risk in such actions. Under the precedents of this and other Circuits, federal courts have jurisdiction over suits seeking the construction of a federal instrument or otherwise turning on federal common law. Second, this suit is not barred by the state courts' jurisdiction over the administration of the estate. The Second Circuit has disparaged the "probate exception" to federal jurisdiction. At a minimum, it has held that federal courts have jurisdiction to declare the rights of parties to assets in an estate, even if those assets might subsequently be distributed in state court proceedings. Third, the Court should not abstain, because none of the relevant abstention doctrines apply. Where federal law governs a case, as it does in this case, federal courts are to exercise their jurisdiction regardless of whether the same federal question could be raised in a state court proceeding. Fourth, the case is not premature. The estate argues that a suit to determine the validity of the lien is not ripe because the Surrogate's Court still must approve the minor's portion of the settlement. But the Second Circuit has repeatedly held that a declaratory judgment claim can present an actual case or controversy even where it is based on contingent rights. Here, the dispute over the lien is concrete and its resolution will even assist the Surrogate's Court in ruling on the appropriateness of the minor's share.

Nor should the Court award Defendant summary judgment based on the statute of limitations. FEHBA preempts the state law statute of limitations that Defendant seeks to apply. Further, the dispute over the lien crystallized only when it became apparent that Defendant had reached a settlement with the alleged tortfeasors, but that she would not honor the lien Empire asserts. In fact, the parties agreed

that Empire would file its suit within 30 days of the recitation in the New York State Supreme Court of the terms of the settlement, and Empire met that deadline. Empire has not missed any relevant deadline, and no conceivable statute of limitations could have passed.

BACKGROUND

A. Contractual and Regulatory Background

FEHBA charges the United States Office of Personnel Management ("OPM") with establishing and regulating health benefits plans for federal employees and their dependents. 5 U.S.C. § 8902(a). Pursuant to this statutory mandate, OPM has entered a federal government contract with the Blue Cross and Blue Shield Association ("BCBSA") to establish the Service Benefit Plan (or "the Plan"), a nationwide fee-for-service plan. *See* 5 U.S.C. § 8903(1); 1997 Statement of Benefits for the Service Benefit Plan at 2 (Exh. C to Compl.) [hereinafter "1997 Statement of Benefits"]; *see generally* 1996 contract between OPM and BCBSA and subsequent amendments (Exh. A to Compl.); 2002 contract between OPM and BCBSA and subsequent amendments (Exh. B to Compl.). In signing the contract, BCBSA acts on behalf of local Blue Cross and Blue Shield companies, which administer the Service Benefit Plan in their respective localities. 1997 Statement of Benefits at 2. Empire is a Blue Cross and Blue Shield company that administers the Plan in New York.

FEHBA also directs OPM to procure such health benefits as the agency "considers necessary or desirable." 5 U.S.C. § 8902(d). In conjunction with this authority, OPM issues to all enrollees in each FEHBA plan a "Statement of Benefits." *See id.* § 8902(d). The Statement of Benefits sets forth the "benefits, including maximums, limitations, and exclusions"; the "procedure for obtaining benefits"; and the "principal provisions of the plan affecting the enrollee and any eligible family members." *Id.* § 8907(b). The Statement of Benefits for the Service Benefit Plan is incorporated into

the OPM-BCBSA contract and is the official description of benefits and other Plan terms. *See* 1997 Statement of Benefits at 2; 1996 contract between OPM and BCBSA, § 2.2(a); 2002 Contract between OPM and BCBSA, § 2.2(a).

One provision in the Statement of Benefits concerns subrogation and reimbursement. Under the Service Benefit Plan, when an enrollee receives benefits in connection with an injury and also receives compensation from the third party who caused the injury, the enrollee must reimburse the local Blue Cross and Blue Shield entity administering the Plan the amount of benefits paid. The subrogation and reimbursement provision states:

> This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.
>
> If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be

used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to

> notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

1997 Statement of Benefits at 12.[1]

Any money recovered through subrogation or reimbursement ultimately inures to the benefit of the United States. This is because the health benefits provided to enrollees under the Service Benefit Plan (as with all FEHBA plans) are subsidized by the United States. The government pays the majority of the premium, with the enrollee paying the remainder. 5 U.S.C. § 8906. These premium funds are then placed in a U.S. Treasury account and disbursed periodically to the local Blue Cross and Blue Shield companies to cover the costs of benefits payments. 5 U.S.C. § 8909(a); 48 C.F.R. § 1632.170(b); Declaration of Clinton Shatzer ¶¶ 4-6 (Exh. A to Declaration of Kieran Bastible, accompanying this Mem.) [hereinafter "Shatzer Decl."]. When a carrier recovers benefits through subrogation and reimbursement, it returns the funds to the Treasury. *See* Shatzer Decl. ¶ 7. Because the United States's own funds are at issue, the government -- in its contract with BCBSA --

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[1] Throughout this brief, we refer to the 1997 Statement of Benefits, since Empire first paid benefits in association with Mr. McVeigh's injuries during that year. Subsequent Statement of Benefits are similar concerning the provisions relevant to this case, including the reimbursement requirement. *See, e.g.*, 1998 Statement of Benefits for the Service Benefit Plan at 12 (Exh. D to Compl.); 1999 Statement of Benefits for the Service Benefit Plan at 12 (Ex. E. to Compl.); 2000 Statement of Benefits for the Service Plan at 12 (Exh. F to Compl.); 2001 Statement of Benefits for the Service Benefit Plan at 86 (Exh. G to Compl.).

has specified that BCBSA and the local Blue Cross and Blue Shield companies shall make a "reasonable effort to seek recovery of amounts [they are] entitled to recover in cases which are brought to [their] attention." 1998 amendment to contract between OPM and BCBSA § 4.1(e) (altering § 2.5) (Exh. A to Compl.); *see also* 2002 contract between OPM and BCBSA § 4.1(h) (altering § 2.5).

Finally, FEHBA contains an express preemption provision. It states: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1) (2000). "The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits." *Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 925 (9th Cir. 1987); *see* H.R. Rep. No. 105-374, at 9, 16 (1997) (provision "strengthen[s] the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live") (Exh. B to Declaration of Kieran Bastible, accompanying this Mem.); *see also* 1996 contract between OPM and BCBSA § 4.1(d) (adding § 2.5(f)) (providing that subrogation shall be done "a single, nation-wide policy" to ensure "consistent treatment").

B. Benefits Claims and Proceedings Involving Mr. McVeigh

At the times relevant to this case, Joseph E. McVeigh was enrolled in the Service Benefit Plan. Compl. ¶ 7. In 1997, Mr. McVeigh suffered injuries in an accident. Compl. ¶ 8; *see also* Answer (nowhere denying ¶ 8 of the Complaint). Between 1997 and 2001, Empire paid benefits under the Service Benefit Plan for medical treatment relating to Mr. McVeigh's injuries. Compl. ¶ 10. Mr. McVeigh died in November 2001. Compl. ¶ 11; Answer (nowhere denying ¶ 11 of the Complaint). Defendant is the administratrix of Mr. McVeigh's estate. Def.'s Stmt. of Undisputed Facts ¶ 2

(Exh. 2 to Def.'s Affirmation in Supp. of Mot. to Dismiss and for Summ. J.). Defendant alleges that the administration of the estate remains ongoing in the Surrogate's Court for New York County. *See id.* ¶ 4.

On behalf of the estate and on her own behalf, Defendant has sued the third parties that allegedly caused Mr. McVeigh's injuries in New York State Supreme Court; Mr. McVeigh's minor child also joined in that suit. *See* Compl. ¶ 12; Tr. of Testimony in *Finn v. Town of Southampton*, Index No. 11335/98 (Mar. 19, 2003) (Exh. C to Declaration of Kieran Bastible, accompanying this Mem.) ("As everyone knows, there are four causes of action involved in this case: a claim for personal injury by Denise Finn, a claim for loss of consortium by Denise Finn, a claim on behalf of the Estate of Joseph McVeigh for pain and suffering, and a wrongful death claim on behalf of his distributees.") [hereinafter "State Court Tr."]. At a hearing in that case on March 19, 2003, counsel for Defendant reported that the parties to the state court action had agreed to settle the estate's claims, Ms. McVeigh's individual claims, and the minor's claims for a total of $3,175,000 million. State Court Tr. at 7 ("It is hereby stipulated and agreed by counsel for the plaintiff and the defendants . . . that the action is settled for the total sum of 3,175,000.").

Prior to the hearing, Empire had notified Defendant's counsel by letter that it had a lien against the estate's portion of the tort settlement in the amount of $157,309.06. *See* Compl. ¶ 14; Letter from Howard F. Wolfson to Thomas J. Stock at 2 (Mar. 11, 2003) (Exh. H to Compl.). In response to that letter, counsel for Defendant disputed the existence of a lien. *See* Letter from Thomas J. Stock to Howard S. Wolfson (Mar. 13, 2003) (Exh. I to Compl.); *see also* Letter from Thomas J. Stock to Alfredo J. Alvarado at 1 (Mar. 7, 2003) (Exh. J to Compl.) (stating that Empire "never has and never will have a lien on the recovery in [the tort] action"). At the March 19 hearing, counsel for Defendant reiterated that "there is a claim of lien by Empire Blue Cross/Blue

Shield of $175,000 approximately, and we dispute the lien." State Court Tr. at 9-10.

Because of the dispute over the lien, counsel for Defendant indicated to the state court at the March 19 hearing that he had "agreed with counsel for the alleged lien holder [*i.e.*, Empire] to hold in escrow the sum of $100,000 until there is a resolution of that lien holder's claim." *Id.* at 10. Defendant and Empire further agreed "that the extent of the lien holder's lien, if any, is still in issue, and that [Empire is] not waiving any portion of their claim at this time, they are merely agreeing that they will not bring any claim against anyone else involved in this case to assert their lien other than the estate of Joseph McVeigh." *Id.* Defendant and Empire also agreed that Empire would "bring any claim that they intend to bring within thirty days or be time barred from doing so." *Id.*

Consistent with its representation to the state court, Empire brought this action for reimbursement within 30 days of the March 19 hearing, on April 18, 2003. Its complaint raises two claims: one for breach of contract and one for declaratory judgment. The contract claim asserts that, "[u]nder the provisions of the Service Benefit Plan, Defendant -- on the estate's behalf -- is obligated to reimburse Empire for the full amount of benefits the Decedent received, upon the estate's recovery from the third parties associated with Decedent's injuries." Compl. ¶ 19. Because "Defendant has flatly rejected Empire's assertion of a lien," she has "breached and imminently will further breach obligations under the Service Benefit Plan." *Id.* Similarly, the Declaratory Judgment claim avers that Defendant has refused Empire's demand for reimbursement and that "an actual and justiciable controversy has arisen between Empire and Defendant" as to Empire's "right to reimbursement of the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries, pursuant to the express terms of the Service Benefit Plan." *Id.* ¶ 23. In this claim, Empire alleges that it "is

entitled to a judgment declaring that, pursuant to the express terms of the Service Benefit Plan, as well as FEHBA, its implementing federal regulations, and federal common law, it has the right to reimbursement from Defendant for the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries." *Id.* ¶ 24.

In its prayer for relief, Empire requests that the Court "declare that Empire has a lien in the amount of $157,309.06 against the settlement proceeds of Defendant Denise Finn McVeigh relating to her state court claim on behalf of Decedent's estate against the third parties alleged to have caused Decedent's injuries." *Id.* at page 8. Empire also requests judgment against the Defendant in the same amount, an order requiring disbursement of the $100,000 escrow account to Empire, and an order directing Defendant to pay the additional amount of $57,309.06 upon receipt of settlement funds in connection with her tort suit on the estate's behalf. *Id.*

ARGUMENT

I. THE COURT SHOULD DENY DEFENDANT'S MOTION TO DISMISS

A. The Court Has Federal Question Jurisdiction

Defendant's principal argument in support of dismissal is that the Court lacks jurisdiction under 28 U.S.C. § 1331 because the case allegedly does not "require the resolution of a substantial Federal question." Def.'s Affirmation ¶ 5. But the Supreme Court has consistently held that a complaint raises a federal question where any one of its claims "necessarily turn[s] on some construction of federal law." *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 9 (1983); *accord City of Chicago v. Int'l College of Surgeons*, 522 U.S. 156, 164 (1997) (even state law claim raises a federal question where it "turn[s] exclusively on federal law"); *see also id.* (a "federal question exists when a 'right or immunity created by the Constitution or laws of the United States [is] an element, and an essential

one, of the plaintiff's cause of action'") (quoting *Gully v. First Nat'l Bank in Meridian*, 299 U.S. 109, 112 (1936)). Here, Empire's claims turn on both the interpretation of a federal government contract, which is federal law, and of federal common law.

1. Empire's Claims Turn on a Federal Government Contract, Which Is Federal Law

That a claim turning on a federal government contract or other federal instrument raises a federal question is illustrated by the Second Circuit's decision in *Marcus v. AT&T Corp.*, 138 F.3d 46 (2d Cir. 1998). There, a consumer brought a "breach of warranty" claim against AT&T, alleging failure to comply with the company's published rates and policies. *Id.* at 55. When the consumer later appealed AT&T's removal of the case to federal court, "AT&T argue[d] that the breach of warranty claim necessarily arises from AT&T's only contract between it and its consumers -- the tariff filed with the FCC in accordance with 47 U.S.C. § 203(a)." *Id.* at 55-56. "Because the tariff is filed with the FCC pursuant to [the Federal Communications Act ("FCA")], AT&T argue[d] the breach of warranty claim arises under federal law." *Id.* at 56. The Second Circuit "agree[d]." *Id.* It found that the source of the rate agreements that appellants sought to enforce was "the tariffs filed in accordance with the FCA." *Id.* These tariffs were not "mere contracts" between private parties; they were "federal law," since they were documents maintained with the FCC that "conclusively and exclusively enumerate the rights and liabilities of the contracting parties." *Id.* (internal quotation marks omitted). Because the tariffs were federal law, and the breach-of-warranty claim hinged on them, the claim "necessarily raise[d] a substantial federal question over which federal courts may properly exercise jurisdiction." *Id.*

Like the claims in *Marcus*, Empire's claims seek enforcement of a federal contractual arrangement that constitutes federal law, thereby raising federal questions.

Each of Empire's claims turns on the reimbursement terms in the Service Benefit Plan's Statement of Benefits. As with the tariffs in Marcus, the Statement of Benefits is not a mere contract between private parties; rather, it has the full force and effect of federal law. To start with, the Statement of Benefits is part of a government contract, with a federal agency -- OPM -- being a party to that contract. Indeed, the Statement of Benefits itself is an promulgation of the agency. Under FEHBA, it is OPM that has responsibility for publishing "an appropriate document" setting forth the benefits "to which the enrollee . . . [is] entitled." 5 U.S.C. § 8907(b). Because the Statement of Benefits is an OPM promulgation, its "provisions are rules under the Administrative Procedure Act, 5 U.S.C. § 551(4)." *Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 80 (4th Cir. 1993). As part of a federal government contract and as an agency rule, the Statement of Benefits is federal law.

FEHBA's express preemption provision further establishes that the Statement of Benefits is federal law. This section provides that the Statement of Benefits has the same legal effect as federal statutes and regulations by stating that "the terms of any [FEHBA] *contract* . . . which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" shall supersede state laws relating to health insurance and plans. 5 U.S.C. § 8902(m)(1) (emphasis added). The Statement of Benefits could not readily supersede state law if it were not federal law.

Because Empire's claims involve construction and enforcement of the Statement of Benefits's reimbursement terms, and because the Statement of Benefits is federal law, Empire's complaint "raises a substantial federal question." *Marcus*, 138 F.3d at 56. On this basis, the Court has jurisdiction. *See generally Price v. Pierce*, 823 F.2d 1114, 1120 (7th Cir. 1987) (breach-of-contract claim falls within federal courts' jurisdiction where it seeks enforcement of

federal housing agreement); *Eatmon v. Bristol Steel & Iron Works, Inc.*, 769 F.2d 1503, 1514-17 (11th Cir. 1985) (breach-of-contract claim "arose under" federal law because relevant contract was "conciliation agreement" entered with federal government); *accord Guardian Nat'l Acceptance Corp. v. Swartzlander Motors, Inc.*, 962 F. Supp. 1137, 1143 (N.D. Ind. 1997); *Amoco Chem. Co. v. Tex Tin Corp.*, 902 F. Supp. 730, 735 (S.D. Tex. 1995).

2. Empire's Claims Turn on Federal Common Law

Alternatively, Empire's complaint falls within the Court's federal question jurisdiction because it turns on the construction of federal common law. "It is beyond dispute that if federal common law governs a case, that case presents a federal question within the subject matter jurisdiction of the federal courts, just as if the case were governed by a federal statute." *Woodward Governor Co. v. Curtiss-Wright Flight Sys., Inc.*, 164 F.3d 123, 126 (2d Cir. 1999). As articulated by the Supreme Court in *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988), there is a two-part test for determining whether a claim is controlled by federal common law. First, "as a threshold matter, a case must implicate 'uniquely federal interests' for federal common law to apply." *Woodward Governor Co.*, 164 F.3d at 127 (quoting *Boyle*, 487 U.S. at 504). Second, there must be a "'significant conflict between some federal policy or interest and the use of state law.'" *Id.* (quoting *O'Melveny & Myers v. FDIC*, 512 U.S. 79, 87 (1994), and citing Boyle, 487 U.S. at 504). Empire's claims, which, again, seek construction and enforcement of the reimbursement provisions of the Service Benefits Plan's Statement of Benefits, satisfy both parts of the test.

Reimbursement under the FEHBA program is an area of uniquely federal concern because it involves the United States's own money. The government subsidizes the health benefits it supplies to its employees, and its contributions are

placed in a special account in the U.S. Treasury from which benefits are paid. *See supra* p. 6. The money that carriers collect in reimbursement when benefits are paid back is, in turn, returned to the U.S. Treasury. *See id.*; Shatzer Decl. ¶ 7. The Second Circuit in *Woodward Governor Co.* recognized that "the obligations to, and rights of, the United States under its contracts" involve uniquely federal interests, and here what is at issue is the right of the United States ultimately to obtain funds in reimbursement pursuant to the terms of its contract for the Service Benefit Plan. The uniquely federal character of this suit is not altered merely because it is a FEHBA carrier, rather than the United States directly, who seeks to collect the money for the government (pursuant to the reimbursement provisions of the FEHBA contract). The rights and "liabilit[ies] of independent contractors performing work for the Federal Government, like the liability of federal officials [themselves], is an area of uniquely federal interest." *Boyle*, 487 U.S. at 505 n.1 (emphasis added); *see Woodward Governor Co.*, 164 F.3d at 128 (noting that suit between private parties can implicate uniquely federal interests if "the United States is exposed to some potential loss").

Not only are uniquely federal interests present in this case, but there is also a significant conflict between those federal interests and the application of state law. A chief Congressional goal undergirding FEHBA is "uniformity in the administration of FEHBA benefits." *Hayes v. Prudential Ins. Co. of Am., Inc.*, 819 F.2d 921, 925 (9th Cir. 1987); *accord Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993). FEHBA's preemption provision overtly seeks to further this objective. *See Caudill*, 999 F.2d at 79. The goal of uniformity finds further articulation in the reimbursement provisions of the contract between OPM and BCBSA for the Service Benefit Plan, which provide that local Blue Cross and Blue Shield companies shall seek reimbursement "under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under this

contract." 1996 contract between OPM and BCBSA § 4.1(d) (adding § 2.5(f)) (Exh. A to Compl.); 1997 amendment to contract between OPM and BCBSA § 4.1(d) (amendment 10) (Exh. A to Compl.); *see also* 2002 contract between OPM and BCBSA § 2.3(g) (Exh. C to Compl.).

The application of state law would "subvert this policy [of uniformity]." *Rievley v. Blue Cross/Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1037 (E.D. Tenn. 1999). For instance, if state law were to apply in reimbursement matters, then enrollees in states with strong policies against subrogation could avoid reimbursement when they obtain a recovery from a third party, whereas enrollees in other states that more readily allow subrogation would have to repay. That would be inequitable, given that all enrollees contribute the same amount toward premiums (*see* 5 U.S.C. § 8906), but enrollees in some states would enjoy an advantage -- namely, the avoidance of reimbursement -- that enrollees in other states would not. *See* Caudill, 999 F.2d at 79 (emphasizing that application of state law in FEHBA benefits suits would be "fundamentally unfair to many federal employees covered by Blue Cross contracts because enrollees in some states would pay higher premiums to cover benefits provided only in other states"). "As an employer, the federal government has an overwhelming interest in ensuring that all of its employees subject to a particular health insurance policy are treated equally regardless of the state in which they live, and the application of state law interferes with this interest." *Id.* at 79.

Both of *Boyle*'s requirements for the application of federal common law, then, are here satisfied, and Empire's claims accordingly are governed by federal common law and subject to federal jurisdiction. The Eighth Circuit reached a similar conclusion in *MedCenters Health Care v. Ochs*, 26 F.3d 865, 867 (8th Cir. 1994), where it held that a FEHBA carrier's claim for reimbursement from an enrollee was subject to federal jurisdiction because "FEHBA pre-empt[s] the state-law rule in this instance." *See also MedCenters*

Health Care v. Ochs, 854 F. Supp. 589, 591-92 (D. Minn. 1993) (in rejecting enrollee's challenge to federal jurisdiction, and then requiring reimbursement, district court held that "federal law controls interpretation of [FEHBA] contractual provision and the resulting rights and obligations of the parties"), *aff'd*, 26 F.3d 865 (8th Cir. 1994). The application of federal common law to -- and thus federal jurisdiction over -- Empire's claims is further bolstered by the myriad decisions from this and other courts finding that the interpretation of FEHBA plan provisions (provisions on which Empire's complaint relies) is governed exclusively by federal law. *E.g., Fed. Plaza Med. Assocs., P.C. v. Palermino*, No. 87 Civ. 6777 (MGC), 1991 U.S. Dist. LEXIS 2167, at *15 (S D.N.Y. Feb. 22, 1991) ("Because the brochure [*i.e.*, the Statement of Benefits] is part of a federal procurement contract, its interpretation is governed by federal law."); *Harris v. Mut. of Omaha Corp.*, 992 F.2d 706, 711 (7th Cir. 1993) (same); *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985) (same).

B. The Probate Exception to Federal Jurisdiction Is Inapplicable in This Instance

Defendant's next argument is that the Court has no jurisdiction because the estate is currently the subject of administration by the New York State Surrogate's Court. *See* Def.'s Affirmation ¶ 20 (relying on *Beach v. Rome Trust Co.*, 269 F.2d 367 (2d Cir. 1959)). Though she does not put it in so many words, Defendant here invokes what has been called the "the probate exception to federal diversity jurisdiction." *Moser v. Pollin*, 294 F.3d 335, 340 (2d Cir. 2002) (emphasis added). Under this exception, "a federal court may not probate a will, administer an estate, or entertain an action that would interfere with pending probate proceedings in a state court or with a state court's control of property in its custody." *Ashton v. Josephine Bay Paul & C.*

Michael Paul Found., Inc., 918 F.2d 1065, 1071 (2d Cir. 1990).

The probate exception is disfavored in the Second Circuit. The Court of Appeals has described it as "'one of the most mysterious and esoteric branches of the law of federal jurisdiction.'" *Id.* at 1071 (quoting *Dragan v. Miller*, 679 F.2d 712, 713 (7th Cir. 1982)). It has characterized the doctrine's rationale -- rooted as it is in the distinction between the "courts of chancery" and the "ecclesiastical courts in England" -- as "dubious." *Id.* (internal quotation marks omitted).

Whatever its general merits, the probate exception has no application in this case. As its title indicates, the exception is to diversity jurisdiction. This case, as we have shown, involves a federal question. The exception does not apply in federal question cases. *See In re Goerg*, 844 F.2d 1562, 1565 (11th Cir. 1988); *Powell v. Am. Bank & Trust Co.*, 640 F. Supp. 1568, 1575 (N.D. Ind. 1986); 15 James Wm. Moore et al., *Moore's Fed. Practice* ¶ 102.92[1] (3d ed. 1999); *cf. Ashton*, 918 F.2d at 1072 (declining to apply probate exception even in diversity context, where case was brought under federal interpleader statute available to diverse parties).

Furthermore, Empire's claims fall outside of the probate exception because its claims for a lien on the settlement proceeds would not, if forced into the state courts, be exclusively cognizable in the Surrogate's Court. As Defendant indicated at the hearing, the State Supreme Court could hear Empire's claim to the lien. State Court. Tr. at 10 (counsel for estate noting at Supreme Court hearing that he might seek "to have this court resolve [the lien] issue" through an "order to show cause") (emphasis added). "The standard for determining whether federal jurisdiction may be exercised is whether under state law the dispute would be cognizable only by the probate court," rather than "in a state court of general jurisdiction." *Lamberg v. Callahan*, 455 F.2d 1213, 1216 (2d Cir. 1972).

Perhaps most important, even assuming that the probate exception has relevance in federal question cases and that the Surrogate's Court has exclusive jurisdiction among the state courts to determine the lien, the doctrine never reaches claims seeking to declare rights to the assets of an estate, as opposed to the actual distribution of the estate's assets or an accounting. "From the earliest probate cases in the federal courts a definite if not always precise line has been drawn between claims seeking to contest management or to effect a distribution of property, and those merely seeking a judgment in personam declaring the plaintiff entitled to receive from the fiduciary an interest in the estate." *Beach*, 269 F.2d at 372. "Merely determining the rights to, as opposed to administering assets, is not proscribed by the probate exception." *Ashton*, 918 F.2d at 1072; *accord Markham v. Allen*, 326 U.S. 490, 494 (1946) ("[W]hile a federal court may not exercise its jurisdiction to disturb or affect the possession of property in the custody of a state court, it may exercise its jurisdiction to adjudicate rights in such property where the final judgment does not undertake to interfere with the state court's possession save to the extent that the state court is bound by the judgment to recognize the right adjudicated by the federal court.").

The first form of relief that Empire seeks in its complaint is a declaration that it has a lien on the estate's settlement proceeds for health benefits it has paid (*see* Compl., Prayer for Relief, ¶ A), and one of Empire's claims is for a declaratory judgment. *See id.* ¶¶ 20-24. Through a declaratory judgment, the Court would simply be adjudicating "a controversy concerning the right of the plaintiff to share in the res"; it would not "undertake the general administration of the [estate's] property." *Beach*, 269 F.2d at 372. None of the precedents involving the probate exception preclude this declaration of rights. It is true that the complaint's prayer for relief additionally seeks distribution of the escrow fund and additional moneys from the settlement proceeds. But each form of relief requested is

to be evaluated on its own merits for purposes of the exception, *see In re Thomas & Agnes Carvel Found.*, 36 F. Supp. 2d 144, 149 (S.D.N.Y. 1999), and Empire unquestionably seeks, as one form of relief, a declaration of rights that the cases uniformly hold to be outside of the exception. In any event, even the forms of relief other than declaratory relief that Empire seeks are not barred by the probate exception because, as noted, this is a federal question case.[2]

C. The Court Should Not Abstain from Exercising Its Jurisdiction

Defendant contends that, "[e]ven assuming that this Court is not required to dismiss the within claims, this Court clearly has the power to decline to assert jurisdiction under the circumstances presented." Def.'s Affirmation ¶ 21. This is an abstention argument, although again not identified in so many words. There are two abstention doctrines that Defendant here might be contemplating -- the one described in *Wilton v. Seven Falls Co.*, 515 U.S. 277, 289-90 (1995), and the one detailed in *Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 818 (1976).

Wilton applies in situations where a litigant seeks declaratory relief. It permits a federal court to decline jurisdiction "in the sound exercise of its discretion" if there are "parallel state proceedings" and if "considerations of

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[2] With respect to Empire's request for distribution to it of its share of the settlement proceeds, it is also worth emphasizing that the probate exception, where it otherwise applies (and, again, that is in diversity cases), only limits the distribution of "property in the custody of a state court." *Markham*, 326 U.S. at 494. The majority of the money that Empire seeks will never become the estate's assets and thus be subject to the Surrogate Court's jurisdiction, since it is specifically being held in an escrow account to avoid its transfer to the estate.

practicality and wise judicial administration" so indicate. *Wilton*, 515 U.S. at 288, 289. *Colorado River* applies where relief other than declaratory relief is sought. It is less permissive than *Wilton*, for it is "'an extraordinary and narrow exception to the duty of a District Court to adjudicate a controversy properly before it.'" *Burnett v. Physician's Online, Inc.*, 99 F.3d 72, 77 (2d Cir. 1996) (quoting *Colorado River*, 424 U.S. at 813). As with *Wilton*, abstention under Colorado River requires parallel proceedings in a state court and "'rests on considerations of wise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation.'" *Id.* at 76 (quoting Colorado River, 424 U.S. at 817). In all instances, the *Colorado River* inquiry is "'heavily weighted in favor of the exercise of [federal] jurisdiction.'" *Id.* (quoting *Moses H. Cone Mem. Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 16 (1983)). The Second Circuit has held that, where -- as is the case with Empire's complaint -- the plaintiff seeks both declaratory and other relief (such as an injunction or damages), *Colorado River* is the governing doctrine, not *Wilton*. *Village of Westfield, N.Y. v. Welch's*, 170 F.3d 116, 124 n.5 (2d Cir. 1999).

Nonetheless, whether it is *Wilton* or *Colorado River* that is implicated, none of the factors guiding the exercise of these abstention doctrines is present in this case. Foremost, these abstention doctrines are more appropriately applied where state law, not federal law, governs the case's substantive legal issues. For example, *Wilton* involved a declaratory judgment action where state law governed. The Supreme Court specifically declined to determine whether the same abstention principles would pertain to "cases raising issues of federal law." *Wilton*, 515 U.S. at 290. Since *Wilton*, the Second Circuit has rejected abstention under *Wilton* if the declaratory action involves "questions of federal law." *Youell v. Exxon Corp.*, 74 F.3d 373, 376 (2d Cir. 1996). Likewise, under *Colorado River*, "the presence of federal issues strongly advises exercising federal

jurisdiction." *City of Westfield, N.Y.*, 170 F.3d at 124. Because Empire's claims are governed by federal law, the Court should reject abstention on that basis.

The relevant factors also do not favor abstention because, under both *Wilton* and *Colorado River*, there must be parallel state court proceedings to which the federal court can defer. For state and federal proceedings to be parallel, they must be "essentially the same; that is, there is an identity of parties, and the issues and relief sought are the same." *Nat'l Union Fire Ins. Co. v. Karp*, 108 F.3d 17, 22 (2d Cir. 1997). Here, Defendant refers to an "administration proceeding now pending" in the Surrogate's Court as the parallel state court matter. Def.'s Affirmation ¶ 22. But the Surrogate's Court proceeding (which McVeigh fails to identify with any specificity) cannot share an identity of parties or issues with this case. Empire is not a party to the "administration proceeding" or to any other pending state court action involving Defendant. It has not received or filed any pleadings in any Surrogate's Court action involving its disputed lien or subrogation rights. Moreover, the probate of an estate does not involve the same legal issues as a creditor's suit seeking relief from the decedent. Without parallel state court proceedings, abstention cannot apply.

Abstention also would not avoid "piecemeal litigation" or otherwise conserve judicial resources. *Burnett*, 99 F.3d at 76. If the determination of Empire's lien were left to the state courts, the appropriate forum for resolution of the lien -- as Defendant has already admitted -- would be the State Supreme Court. *See* State Court. Tr. at 10. Hence, if this Court relinquished jurisdiction, there would still be two ongoing proceedings -- one in the Supreme Court and one in the Surrogate's Court. Dismissing or staying the federal suit in favor of an additional state court suit would not promote judicial economy. Furthermore, if Defendant were to raise the issue of Empire's lien in state court (such as through the "show cause" order she threatened in the State Supreme Court, *see id.*), Empire could rightfully remove that case to

this Court. No matter how Defendant might artfully plead the issue, the determination of the lien turns on the construction of the terms of a federal government contract, thereby giving Empire a removal right. *See Marcus v. AT&T Corp.*, 138 F.3d 46, 55-56 (2d Cir. 1998). Accordingly, the practical result of abstention might be that the parties return here, albeit after having had to introduce the lien claim in state court and then remove the case to this Court.

For all of these reasons, the Court should decline Defendant's invitation to abstain from exercising its jurisdiction. The federal courts have "a 'virtually unflagging obligation' to exercise their jurisdiction," *Burnett*, 99 F.3d at 76 (quoting *Colorado River*, 424 U.S. at 817), and the circumstances of this case do not discharge the Court of that obligation.

D. This Action Is Not Premature

Defendant's last dismissal argument is that "it is premature and improper" to hear this case because the "Surrogate's Court has not yet approved any settlement." Def.'s Affirmation ¶ 27. Thus, Defendant maintains that "[i]t is unknown if any settlement proceeds will be paid to the Estate" from which Empire could collect its lien. *Id.* In Defendant's view, the Court cannot "grant a lien against something that does not yet exist and may never exist, against a person or entity as yet unknown." *Id.*

Contrary to Defendant's assertion, the Court can -- at a minimum -- issue a declaratory judgment determining Empire's right to reimbursement, regardless of whether any settlement has yet been approved. The Declaratory Judgment Act allows a court to declare rights of litigants in an "actual controversy" within the federal courts' jurisdiction. 28 U.S.C. § 2201(a). As with any claim, federal courts may not resolve purely academic or abstract legal questions in the context of a declaratory suit. *See, e.g., Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 239-40 (1937). However, "[t]hat the liability may be contingent does not

necessarily defeat jurisdiction of a declaratory judgment action." *Assoc. Indemn. Corp. v. Fairchild Indus., Inc.*, 961 F.2d 32, 35 (2d Cir. 1992). "Where there is an actual controversy over contingent rights, a declaratory judgment may nevertheless be granted." *Am. Mach. & Metals, Inc. v. De Bothezat Impeller Co.*, 166 F.2d 535, 536 (2d Cir. 1948); *accord Lumbermens Mut. Cas. Co. v. Borden Co.*, 241 F. Supp. 683, 690 (S.D.N.Y. 1965); *Nat'l Railroad Passenger Corp. v. Consol. Rail Corp.*, 670 F. Supp. 424, 430 (D.D.C. 1987).

Indeed, "litigation over insurance coverage has become the paradigm for asserting jurisdiction despite 'future contingencies that will determine whether a controversy ever actually becomes real.'" *Assoc. Indemn. Corp.*, 961 F.2d at 35 (quoting 10A C. Wright, A. Miller & M. Kane, *Federal Practice & Procedure* § 2757, at 586 (2d ed. 1983)). The Court of Appeals's decision in *E.R. Squibb & Sons, Inc. v. Lloyd's & Cos.*, 241 F.3d 154 (2d Cir. 2001), nicely illustrates the exercise of jurisdiction in an insurance setting where the claims were based on the occurrence of contingent events. In *E.R. Squibb*, a drug manufacturer faced mounting liability in litigation involving one of its products. The manufacturer, Squibb, had primary insurance policies with a coverage limit of $100 million. *Id.* at 159. Squibb sued several of its excess insurers for a declaration that the excess insurance policies would cover liability over $100 million. *Id.* The excess insurers argued that, because Squibb's liabilities had not yet exceeded that amount, the declaratory judgment action was premature. *Id.* The court disagreed, stating that the only real issue was the "practical likelihood" that the contingency would occur. *Id.* at 177. Because Squibb's liability already approached $100 million, the fact that an additional 900 claims were pending against Squibb convinced the court that the contingency likely would ultimately transpire. *Id.*

In Empire's case, the contingency is more imminent and arguably more certain than in *E.R. Squibb*. Although

Defendant has not yet received any settlement proceeds, she did sue the alleged tortfeasors and has agreed to settle the suit. Empire does not dispute that its right to part of the proposed settlement proceeds is conditional on the settlement becoming final, but the settlement now verges on fruition. Had Empire filed for declaratory judgment *before* Defendant ever filed her lawsuit, its rights might have been more hypothetical than actual. But that is not this case. Instead, all that remains is for the Surrogate's Court to approve the part of the settlement relating to the decedent's minor child. Because the facts indicate that a settlement is potentially at hand, Empire's claim for a declaration of its rights to a share of the settlement proceeds is not premature.

Additionally, resolution of Empire's lien rights would have an immediate and concrete impact on any proceeding by the Surrogate's Court to approve the settlement. The Surrogate, if Defendant's statements are to be believed, must judge the fairness and propriety of the minor's part of the settlement. That task is complicated by the fact that some of the money sits in escrow awaiting resolution of the lien issue, leaving the Surrogate to guess the total amount that might be available for distribution. And the Surrogate cannot fully compare the minor's portion of the settlement to the estate's portion to determine if the minor's share is equitable without knowing what amount of the proceeds the estate will be permitted to keep. Put differently, a settlement that appears to compensate the estate too generously might become more acceptable if it is clear that the estate will have to relinquish some of its recovery to a third party. Thus, this Court's resolution of Empire's claims will clarify an issue that currently clouds the tort settlement.

That, in fact, was the reason Defendant and Empire agreed that Empire would, within 30 days of the announcement of the settlement at the State Supreme Court, file an action to determine its lien. Having resolved that Empire should bring the case within a 30-day deadline so as to clear title to the funds, Defendant now maintains that the

case cannot be brought -- potentially for months -- until the Surrogate approves the settlement. Defendant's position is not only inconsistent with the rule that declaratory relief can be sought where events remain contingent, but is disingenuous, given Defendant's insistence on the 30-day filing deadline.

Empire will concede that its requests for actual distribution of the escrow fund and additional settlement amounts to it (from the estate's portion) might not become ripe until final approval of the settlement. Because Empire is not a party to the Surrogate's Court proceeding, it cannot predict when that approval might occur. However, approval could come at any time. If it happens before this Court rules on Empire's request for declaratory relief, Empire's other requests for relief would be fully cognizable. *See* Fed. R. Civ. P. 54(c) (noting that District Court should award relief appropriate at time of *final* judgment). In the meantime, the Court has authority to declare Empire's right to a lien, regardless of whether the Surrogate has or ever will approve the settlement.

II. THE COURT SHOULD DENY DEFENDANT'S REQUEST FOR SUMMARY JUDGMENT

Defendant does not clearly delineate the bases for her summary judgment motion. Defendant appears to argue that summary judgment is warranted because of a state law statute of limitations and because the Defendant is an estate, not an actual Service Benefit Plan enrollee. Both arguments are meritless.

On the statute of limitations, Defendant contends that section 1810 of the New York State Surrogate's Court Procedure Act applies to this action. Citing correspondence between the parties, Defendant argues that Section 1810 required this action to be brought within 60 days of a 1999 letter in which Defendant supposedly rejected Empire's lien claim. Def.'s Affirmation ¶ 24. As an initial matter, the Court should recognize the inconsistency in this argument

with Defendant's other positions. In one part of her brief, Defendant argues that this action is premature because the Surrogate has not approved the settlement, yet now she asserts that the action is too late. In any event, under FEHBA's express preemption section, FEHBA preempts all state laws that relate to "coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). This includes state statutes of limitations that litigants seek to utilize in benefits matters. *See, e.g., Fuller v. Blue Cross & Blue Shield of Fla., Inc.*, 677 F. Supp. 1131, 1133 (N.D. Fla. 1987).

Even if the state limitations period did apply, its requirement that an action be filed within 60 days of rejection of a claim was not triggered in 1999. The correspondence shows that Defendant did not reject the claim at the time, but sought to begin a dialogue to better understand the legal basis for the claim of lien and vowed to keep Empire abreast of developments in the tort action. *See* Letter from Victor Carr to David Berger (Dec. 17, 1999) (Exh. 5 to Def.'s Affirmation). The state law also only applies where the suing party seeks to collect a debt from the general assets of an estate, not from specifically segregated funds. *Puro v. Puro*, 350 N.Y.S.2d 931, 935-36 (N.Y. Sup. Ct. 1972). Finally, if Empire had filed a court action in 1999, there would have been no "actual controversy" sufficient for a declaratory judgment, since there was no inkling at the time that there would ever be any recovery of any sort.

As to Defendant's claim that reimbursement is available only from a "member" (Def.'s Affirmation ¶ 28), with Defendant's argument presumably being that recovery cannot be made from the estate of a no-longer-living member, there is nothing in the Statement of Benefits (or other FEHBA contractual documents) suggesting that the member's debt should not -- as with all other debts -- redound to his estate upon his death. *See Tulsa Prof. Collection Servs., Inc.*, 485 U.S. 478, 493 (1988) (Rehnquist,

C.J., dissenting) ("probate codes universally require that the estate settle the debts of the decedent"). In FEHBA matters, the courts have not distinguished between members and the estates of members. *See, e.g., Robinson v. Humana Group Health Plan*, 1996 U.S. Dist. LEXIS 16578 (D.D.C. Nov. 4, 1996) (addressing claims for benefits by estate of member).[3]

CONCLUSION

The Court should deny Defendant's motions to dismiss and for summary judgment.

Respectfully submitted,

EMPIRE BLUE CROSS &
BLUE SHIELD

By: /s/

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[Affidavit of Service omitted for printing.]

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[3] Ultimately, summary disposition will be appropriate in this case -- but in *Empire*'s favor. There can be no reasonable dispute that Empire has a right of reimbursement under the terms of the Statement of Benefits and the amount is readily discernible. Empire will shortly, by separate motion, move for summary judgment on its claims.

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,	)	
Plaintiff,	)	
v.	)	Civil Action No. 03-CV-2728 (DC)
DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH,	)	
Defendant.	)	

DECLARATION IN SUPPORT OF OPPOSITION TO DEFENDANT'S MOTION TO DISMISS OR FOR SUMMARY JUDGMENT

KIERAN X. BASTIBLE affirms under penalty of perjury:

1. I am associated with the law firm of Morrison Cohen Singer & Weinstein, LLP, attorneys for Empire Blue Cross Blue Shield. As such, I am familiar with the facts and procedural history of this case. I submit this declaration in support of Empire's opposition to Defendant's motion to dismiss and for summary judgment. By submitting this declaration I place before the Court the pertinent exhibits for the Court's consideration of Empire's opposition to Defendant's dismissal and summary judgment motion.

2. Attached as Exhibit A to this declaration is the affidavit of Clinton Shatzer.

3. Attached as Exhibit B to this declaration is a true copy of H.R. Rep. No. 105-374, a report of the U.S. House of Representatives Committee on Government Reform and Oversight concerning the Federal Employees Health Care Protection Act of 1997.

4. Attached as Exhibit C to this declaration is a true copy of the transcript of the settlement conference held March 19, 2003, in New York State Supreme Court, Suffolk County, in the matter of *Finn v. Town of Southampton*, Index No. 011335/98 (Suffolk County).

Respectfully submitted,

By: /s/
Kieran X. Bastible

FILED
FEB 24 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 05-200

IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.
Doing business as Empire Blue Cross Blue Shield,
Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,
Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit

JOINT APPENDIX
VOLUME 2

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Petition for Certiorari Filed August 8, 2005
Certiorari Granted January 6, 2006

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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

1996

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO: 1996
EFFECTIVE: 1/1/96

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereinafter called the OPM, the Agency, or the Government.

AND

CONTRACTOR: Blue Cross and Blue Shield Association Service Benefit Plan
hereinafter also called the Carrier.
Address: 1310 G Street, N.W., Suite 800
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract.

FOR THE CARRIER	FOR THE GOVERNMENT
Alan P. Spielman Name and Title of Signer *(Type or print)*	Lucretia F. Myers Name of Contracting Officer *(Type or print)*
Senior Vice President, Federal Programs Title of Signer	Assistant Director for Insurance Programs Title of Contracting Officer
Alan P. Spielman Signature of Person Authorized to Execute Contract	Lucretia F. Myers Signature of Contracting Officer
12/27/95 Date Signed	December 28, 1995 Date Signed

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PART II - BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1998)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Registration Form within the time and under the conditions specified in the regulations. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such registration to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, annuitants, former spouses, and former employees and dependents (and eligible members of their families) who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 1996)

(a) The Carrier shall provide the benefits as described in the Certified Brochure Text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier (or Plan), after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the

Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in their judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 1996)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided,* however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9 *Claims Processing,* forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the Certified Brochure Text *(Appendix A).* However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) Overpayments. If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. The Carrier shall follow general business practice and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Diligent effort to recover overpayments means that upon discovering that an overpayment exists, the Carrier shall--

(1) Send a written notice of overpayment to the member or provider that provides: (A) an explanation of when and how the overpayment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount overpaid, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered;

(5) Make diligent effort to recover overpayments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been

appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7) The Carrier may charge the contact for benefit payments made erroneously but in good faith provided that it can document that it acted with due diligence as described above.

(8) Maintain records that document individual unrecovered overpayment collection activities for audit or future reference.

(h) Overpayment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the Certified Brochure Text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1996)

(a) The Carrier's subrogation rights, procedures and policies, including recovery rights, shall be in accordance with the provisions of the Certified Brochure Text.

(b) Subrogation recoveries may be reduced by any legal fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 1991)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Model Guidelines for Coordination of Benefits (COB) as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB

provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Model Guidelines implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 1996)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 C.F.R. 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 C.F.R. 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (JAN 1996)

The processes for filing health benefit claims and for court review of disputed health benefit claims under the FEHB are as described at FEHBAR 1652.204-72.

SECTION 2.9
CLAIMS PROCESSING (JAN 1996)

A standardized claims filing process shall be used by all participating fee-for-service, individual-practice prepaid, or mixed-model prepaid FEHB carriers. Beginning in 1996, the Carrier shall develop and apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) By the year 2000, the majority of provider claims should be submitted electronically;

(2) By January 1996, all physicians shall be notified that future claims must be submitted electronically or on the Health Care Financing Administration 1500 form;

(3) Beginning no later than June 1996, the Carrier shall not use any unique physician claim form(s) for such FEHB member claims;

(4) Beginning September 1996, Carrier should reject all such claims submitted on forms other than the HCFA 1500 form and shall explain the reason on the Explanation of Benefits form; and

(5) Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10 CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

PART IV -- SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 1996)

(a) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) In the event the contract is terminated for any reason, no Member shall be entitled to benefits for services or supplies received after the last day of his or her pay period in which such termination occurs. Nor shall the Member be entitled to the conversion privilege set forth in section 2.4 after contract termination.

(b) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(c) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(d) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individual (non-group)policies of liability insurance that are issued to and in the name of the Member.

The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which a Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) All Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under this contract.

(e) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) In computing liability, when the Blue Cross and Blue Shield Service Benefit Plan ("this Plan") is not the Primary payer:

(1) the benefits payable by this Plan shall be determined on a claim by claim basis, except that (i) the benefits payable are limited to benefits for services and supplies set forth in the Certified Brochure Text; and (ii) the benefits payable shall be determined only for those claims in excess of $100, except in the case where the Primary payer is Medicare; and

(2) benefits shall not be payable for services and supplies that are provided beyond the day and visit limitations and the lifetime maximums set forth in the Certified Brochure Text.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under this contract.

(f) Section 3.1 Payments (FEHBAR). The following subsection is added:

(e) In the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(g) Section 3.2. Accounting and Allowable Cost (FEHBAR). As required by Public Law 101-508, § 8909 of title 5, U.S.C., Sections 3.2(b)(2)(ii) and 3.2(b)(2)(iv)(B) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(h) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(i) Section 3.2 Accounting and Allowable Cost (FEHBAR). The note at the end of this section is modified as follows:

[NOTE: As required by subsection (a)(1) of this section, the Carrier, not later than 120 days after the end of the contract period, shall furnish OPM for that period an accounting of its operations under the contract.]

(j) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special Reserve held by or on behalf of the Carrier is to be used only for

payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(k) PART V - REQUIRED CLAUSES Sections 5.30, 5.31, 5.32. Cost Accounting Standards, part 30 of the FAR, has not yet been implemented for the FEHBP. Sections 5.30, 5.31 and 5.32 are not applicable to this contract.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the Certified Brochure Text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the Carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 1991)

A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the Carrier, a charge to the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 1996)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract 90 percent of the Association dues which the Plan otherwise would charge to the contract.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO: 1997
EFFECTIVE: 01/01/97

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereinafter called the OPM, the Agency, or the Government

AND

CONTRACTOR: Blue Cross and Blue Shield Association Service Benefit Plan
hereinafter also called the Carrier.
Address: 1310 G Street, N.W., Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract.

FOR THE CARRIER	FOR THE GOVERNMENT
Alan P. Spielman	Lucretia F. Myers
Name of Signer *(Type or print)*	Name of Contracting Officer *(Type or print)*
Senior Vice President Federal Programs	Assistant Director for Insurance Programs
Title of Signer	Title of Contracting Officer
Alan P. Spielman	Lucretia F. Myers
Signature of Person Authorized to Execute Contract	Signature of Contracting Officer
12/20/96	December 20, 1996
Date Signed	Date Signed

1. All references to the 1996 contract year are changed to 1997.

2. The Table of Contents is amended, as follows:

5.14 UTILIZATION OF SMALL, SMALL DISADVANTAGED AND WOMEN-OWNED SMALL BUSINESS CONCERNS

5.31 DISCLOSURE AND CONSISTENCY OF COST ACCOUNTING STANDARDS
5.32 ADMINISTRATION OF COST ACCOUNTING STANDARDS

5.50 DEFAULT (FIXED-PRICE SUPPLY AND SERVICE)

5.55 EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS AND VETERANS OF THE VIETNAM ERA
5.56 AUTHORIZATION AND CONSENT
5.57 NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT
5.58 MANDATORY INFORMATION FOR ELECTRONIC FUNDS TRANSFER PAYMENT
5.59 CERTIFICATION OF NONSEGREGATED FACILITIES

PART VI – APPENDICES

A- BROCHURE TEXT

3. Section 1.1, DEFINITIONS OF FEHB TERMS, is amended to JAN 1997 and amended by adding the following:

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

(FFS)

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under this part, the terms "carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

4. Section 1.9, FEHB QUALITY ASSURANCE, is amended to JAN 1997 and amended as follows:

(a)

• • •

(6) Assessing Quality of Health Care. The Carrier agrees to collect data on the condition-specific patient outcomes endorsed by the Foundation for Accountability (FAcct) as requested by the OPM for services rendered through the Carrier's Preferred Provider Organization and/or Point of Service networks, and provide statistical reports, in accordance with FAcct guidelines when the data is reasonably available. For Contract Year 1997, the Carrier may be asked to collect data on one or more, but no more than three, outcomes on a pilot basis either in a specified geographic locality or nationwide. Depending on the experience during Contract Year 1997, such data collection may be expanded in future contract years.

(b) The Carrier shall conduct a program to assess its vulnerability to fraud and shall operate a system designed to detect fraud internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members.

(c) The Carrier shall keep complete records of its quality assurance procedures and fraud program and the results of their implementation and make them available to the Government as determined by OPM. If the Carrier cannot separate FEHB claims from all other claims, the Carrier may report compliance based on all claims and indicate this on the report.

(d) The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud program pursuant to this paragraph (d) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for that contract year -- that are subject to the administrative expenses limitation specified at Appendix B; *provided* the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

5. Section 1.13, INFORMATION AND MARKETING MATERIALS, is amended to JAN 1997 and amended as follows:

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. OPM, in its sole discretion, may order the Carrier to print and distribute the agreed-upon brochure text, in a format and quantity approved by OPM. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure to all Federal employees, annuitants, former spouses and former employees and dependents enrolled in the Plan. The Carrier shall also distribute the document(s) to Federal agencies to be made available to such individuals who are eligible to enroll under this contract. The Carrier may print additional FEHB brochures for distribution or its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed-upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it does not conform to the agreed-upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

6. The word "subcontract" in Section 1.16, SUBCONTRACTS, subparagraph (b)(3) is amended to read "subcontractor".

7. Section 2.5, SUBROGATION, is amended to JAN 1997 and paragraph (a) is amended, as follows:

(a) The Carrier's subrogation rights, procedures and policies, including recovery rights, shall be in accordance with the provisions of the agreed-upon brochure text.

8. Section 2.8, FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS, is amended to MAR 1995, the citation (FEHBAR 1652.204-72) added to the heading and the section is amended,

as follows:

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to

make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives

evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

9. Section 3.1, PAYMENTS, is amended to MAY 1992.

10. Section 4.1, ALTERATIONS IN CONTRACT, is amended as follows:

Section 4.1 is amended to APR 1984 and the following phrase is added after the heading:

Portions of this contract are altered as follows:

Section 4.1 - replace existing 4.1(d)(f) with new 4.1(d)(f) to read:

(f) Effective January 1, 1997, all participating plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under this contract.

11. Section 4.8 - replace existing 4.8 with new 4.8 to read:

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 1997)

(a) For the purposes of applying the special provisions in this Section, the Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed by phone or facsimile, the prescription order shall be processed within two business days so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed by mail, the prescription order shall be processed within five business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 96 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 96

percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the deductible and coinsurance for a 21 day prescription filled at a Preferred Retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the deductible and coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below. Use of the waiver will not reduce the total annual deductible required in the brochure text at Appendix A.

(2) The Carrier shall provide the enrollee a written or telephone notice no later than 2 business days prior to the end of the service standard timeframes stated in (a)(1) and (a)(2). This notice shall:

(i) advise the enrollee that the Mail Order Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable deductible and coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred Retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver; and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

12. Section 4.9 - replace existing 4.9 with new 4.9 to read:

SECTION 4.9

(FFS)

52.219-9 (As amended) SMALL, SMALL DISADVANTAGED AND WOMEN-OWNED SMALL BUSINESS PILOT SUBCONTRACTING PLAN (JAN 1997)

(a) This clause does not apply to small business concerns.

(b) "Subcontract," as used in this clause, means any agreement (other than one involving an employer-employee relationship) entered into by the Carrier or its subcontractor calling for supplies or services required for performance of the contract or subcontract, except for agreements with providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

(c) The Carrier, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan which separately addresses subcontracting with small business concerns, with small disadvantaged business concerns and with women-owned small business concerns. The subcontracting plan shall be included in and made a part of the resultant contract. The plan shall be negotiated within the time specified by the Contracting Officer.

(d) The Carrier's subcontracting plan shall include the following:

(1) Goals, expressed in terms of percentages of total planned subcontracting dollars, for the use of small business concerns, small disadvantaged business concerns and women-owned small business concerns as subcontractors. The Carrier shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs.

(2) A statement of–

(i) Total dollars planned to be subcontracted;

(ii) Total dollars planned to be subcontracted to small business

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

1998

1998 Amendments
Fee For Service Contracts

1. All references to the 1997 contract year are changed to 1998.

2. On the first page of the contract, the contractor's signature lines have been revised to make it clear that the signer is the person authorized to execute the contract. Superfluous language on the page is deleted.

3. The Table of Contents is amended to incorporate technical and editorial changes, to add new clauses, to delete obsolete FAR clauses, and to replace five (5) FAR clauses with FEHB-specific clauses, as follows:

1.20 CERTIFICATION UNDER P.L. 104-191 (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)

2.11 BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY

5.29 TAXES--FOREIGN NEGOTIATED BENEFITS CONTRACTS

5.34 INTEREST (FEHBAR MODIFICATION OF FAR)

5.38 CHANGES--NEGOTIATED BENEFITS CONTRACTS

5.40 GOVERNMENT PROPERTY (NEGOTIATED BENEFITS CONTRACTS)

5.46 (RESERVED)

5.49 FEHBP TERMINATION FOR CONVENIENCE OF THE GOVERNMENT--NEGOTIATED BENEFITS CONTRACTS

5.50 FEHBP TERMINATION FOR DEFAULT--NEGOTIATED BENEFITS CONTRACTS

5.60 SUBCONTRACTS FOR COMMERCIAL ITEMS AND COMMERCIAL COMPONENTS

Appendix D-a. JANUARY 1998
Appendix E. JANUARY 1996
Appendix F. JANUARY 1998

4. In Section 1.1, DEFINITIONS OF FEHB TERMS, is redated JAN 1998 and the definitions of "Subcontractor" and "Letter of Credit" are amended to conform to the definitions in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), as follows:

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under FEHBAR 1632.170(b), the terms "carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

5. Section 1.4, INCORPORATION OF LAWS AND REGULATIONS, is redated JAN 1998 and the reference to the FAR clause has been replaced with an FEHB-specific clause reference in the contract, as follows:

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the change will be made effective for the contract period subsequent to the period in which the change is promulgated and, if the change is promulgated in November or December, the change will not be effective until the second contract year following the year in which the change is promulgated; unless (i) The Carrier agrees to an earlier date or (ii) the change is ordered by the Contracting Officer pursuant to the *Changes--Negotiated Benefits Contracts* clause of the contract.

6. Section 1.5, RECORDS AND INFORMATION TO BE FURNISHED BY OPM, is redated JAN 1998 and amended to reflect new procedures for enrollment reconciliation, as follows:

8. PART IV –SPECIAL PROVISIONS is deleted and replaced with the following:

PART IV–SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 1999)
(FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(b) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(c) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(d) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(e) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows: Notwithstanding (g)(7)(ii), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 2.3(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(f) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a

contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(g) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the Member.

The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(h) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(i) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):
OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(j) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(k) Section 3.2 Accounting and Allowable Cost (FEHBAR). As required by Public Law 101-508, § 8909 of title 5, U.S.C., and Section 3.2(b)(2)(ii) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or

plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(l) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows: Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(m) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:
The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(n) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(o) Sections 5.30, 5.31, and 5.32. The Cost Accounting Standards, Chapter 1, Part 30 and Chapter 99 of the FAR, do not apply to the FEHB Program for this contract year, except to the extent compliance with specific standards is required by the cost principles in FAR Chapter 1, Subpart 31.2 and FEHBAR Subpart 1631.2.

(p) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) if title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

2002

BEST AVAILABLE COPY

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039 AMENDMENT NO: 2002
EFFECTIVE: January 1, 1960 EFFECTIVE: January 1, 2002

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereinafter called the OPM, the Agency, or the Government

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereinafter also called the Carrier

Address: 1310 G Street, NW., Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
Stephen W. Gammarino	Abby L. Block
Name of Person Authorized to Execute Contract *(Type or print)*	Name of Contracting Officer *(Type or print)*
Senior Vice President, FEP/IHR	Assistant Director for Insurance Programs
Title	Title
Signature	Signature
12/18/01	12/31/01
Date Signed	Date Signed

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PART II - BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form, or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, annuitants, former spouses, and former employees and dependents (and eligible members of their families) who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of

such benefit the reasons and justification for its determination. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 1999)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information *provided* which the Carrier may reasonably request, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9, *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) *Overpayments.* If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Diligent effort to recover overpayments means that upon discovering that an overpayment exists, the Carrier shall--

(1) Send a written notice of overpayment to the member or provider that provides: (A) an explanation of when and how the overpayment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount overpaid, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered;

(5) Make diligent effort to recover overpayments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7)(i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it acted with due diligence as described above.

(ii) Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii).

(8) Maintain records that document individual unrecovered overpayment collection activities for audit or future reference.

(h) Overpayment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1997)

(a) The Carrier's subrogation rights, procedures and policies, including recovery

rights, shall be in accordance with the provisions of the agreed upon brochure text.

(b) Subrogation recoveries may be reduced by any legal fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS
(JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(h).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995)
(FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause:

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
CLAIMS PROCESSING (JAN 2001)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Health Care Financing Administration 1500 form or the UB-92 form;

(3) The Carrier shall not use any unique provider claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the HCFA 1500 form or the UB-92 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

SECTION 2.11
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 1998)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, and the balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers. This provision does not apply to debarred providers (see Section 2.7).

SECTION 2.12
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2000)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that

continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements that extend beyond the date of the Carrier's termination include, but are not limited to, offering conversion contracts to enrollees during the 31-day extension of coverage for conversion, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying claims incurred prior to the termination date.

PART IV—SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2002)
(FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.9 FEHB Quality Assurance. The following subsection is added to subsection 1.9(a):

(5) The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(a)(1).

(b) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(c) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(d) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(e) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(f) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows: Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 2.3(b). The term "repeated" in the

previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(g) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(h) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the Member.

The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(i) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(j) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):
OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(k) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the

agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(l) Section 3.2 Accounting and Allowable Cost (FEHBAR). As required by Public Law 101-508, § 8909 of title 5, U.S.C., and Section 3.2(b)(2)(ii) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(m) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows: Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(n) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:
The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(o) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(p) Sections 5.30, 5.31, and 5.32. The Cost Accounting Standards, Chapter 1, Part 30 and Chapter 99 of the FAR, do not apply to the FEHB Program for this contract year, except to the extent compliance with specific standards is required by the cost principles in FAR Chapter 1, Subpart 31.2 and FEHBAR Subpart 1631.2.

(q) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative

Blue Cross® and Blue Shield® Service Benefit Plan

1997

A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Authorized for distribution by the:

Federal Employees Health Benefits Program

RI 71-5

Blue Cross® and Blue Shield® Service Benefit Plan

The Blue Cross and Blue Shield Association (Carrier), on behalf of Blue Cross and Blue Shield Plans, has entered into Contract No. CS 1039 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Carrier and are referred to as Local Plans in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1997 and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Blue Cross and Blue Shield Service Benefit Plan for 1997 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records, and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/FEP-8440 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, *e.g.*, to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers.** It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits,** on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are generally paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification;** generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare.** And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

General Limitations *continued*

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you more for covered services than any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge.

General Limitations *continued*

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's Standard Option surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance up to the limiting charge amount that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, ask the Carrier for guidance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 11); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction, or sexual inadequacy
- Not specifically listed as covered
- Experimental or investigational (see Definitions), except for the clinical trials benefit on page 19
- Not provided in accordance with accepted professional medical standards in the United States

Blue Cross® and Blue Shield® Service Benefit Plan

1998

A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Visit this Plan's WEB page at http://www.fepblue.org

Authorized for distribution by the:

United States Office of Personnel Management

FEHB Federal Employees Health Benefits Program

RI 71-5

Blue Cross® and Blue Shield® Service Benefit Plan

The Blue Cross and Blue Shield Association (Carrier), on behalf of Blue Cross and Blue Shield Plans, has entered into Contract No. CS 1039 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Carrier and are referred to as Local Plans in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1998, and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Blue Cross and Blue Shield Service Benefit Plan for 1998 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records, and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/FEP-8440 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, *e.g.*, to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Local Plan; check your phone book for the number. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are generally paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service. When this Plan pays secondary, it will generally only make up the difference between the primary plan's benefit payment and this Plan's coverage. Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances, where there is no adverse effect on the member, this Plan may also take advantage of any provider discount arrangements the primary plan may have and make up only the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities

General Limitations *continued*

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called **the equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan (see your phone book for the number) for assistance.

General Limitations *continued*

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

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General Exclusions

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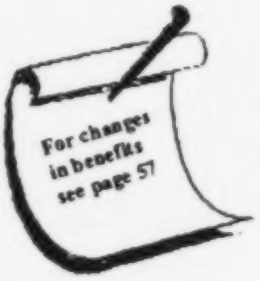
- Not provided in accordance with accepted professional medical standards in the United States

BEST AVAILABLE COPY

Blue Cross® and Blue Shield® Service Benefit Plan

1999

A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association



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Enrollment code for this Plan:

101 High Option Self Only
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Visit the OPM website at http://www.opm.gov/insure

and

this Plan's website at http://www.fepblue.org

Authorized for distribution by the:

United States
Office of
Personnel
Management

FEHB
Federal Employees
Health Benefits Program

RI 71-5

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When you need help with Plan benefits, or getting your ID card, call your Local Plan; check your phone book for the number. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are generally paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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Get the most value for your benefit dollar.

Use a Preferred provider when selecting your health care practitioner. Your out-of-pocket expenses will be reduced and the provider will submit claims for you. Your next best choice is a Participating provider, one who accepts the Participating Provider Allowance as payment in full. If you use a Non-participating provider, your out-of-pocket costs will increase.

When you call to obtain precertification, be sure also to verify whether the hospital is a Preferred, Member, or Non-member hospital. Use of Non-member hospitals will increase your out-of-pocket costs.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is the official statement of benefits on which you can rely.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service. When this Plan pays secondary, it will generally only make up the difference between the primary plan's benefit payment and this Plan's coverage subject to this Plan's applicable deductibles, coinsurance and copayments (see pages 43-44 for exceptions when Medicare is the primary payer). Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances, where there is no adverse effect on the member, this Plan may also take advantage of any provider discount arrangements the primary plan may have and make up only the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan. When this Plan pays secondary to primary coverage you may have from a prepaid plan, this Plan's benefits will be determined based on your out-of-pocket liability under the prepaid plan (generally the prepaid plan's copayment), and subject to this Plan's deductibles, coinsurance and copayments (see page 44 for exceptions when a Medicare prepaid plan is the primary payer).

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

General Limitations *continued*

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the **equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

General Limitations *continued*

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see Definitions). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 11); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction, or sexual inadequacy
- Not specifically listed as covered
- Experimental or investigational (see Definitions), except for devices classified by the U.S. Food and Drug Administration as Category B Non-experimental/Investigational Devices and the clinical trials benefit on page 19
- Not provided in accordance with accepted professional medical standards in the United States

Blue Cross® and Blue Shield® Service Benefit Plan

2000

A Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product

Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Visit the OPM website at http://www.opm.gov/insure

and

our website at http://www.fepblue.org

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Retirement and
Insurance Service

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Federal Employees
Health Benefits Program

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Introduction

Blue Cross® and Blue Shield® Service Benefit Plan

This brochure describes the benefits you can receive from the Blue Cross and Blue Shield Service Benefit Plan under its contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Blue Cross and Blue Shield Association and are referred to as Local Plans in this brochure.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on pages 4-5. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to the Blue Cross and Blue Shield Service Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plans (FFS). This Plan is a FFS plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What if we deny your claim or request for pre-authorization? This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions - Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations - Rules that affect your benefits. This section describes limits that can affect your benefits.
9. Fee-for-Service Facts. This section contains information about precertification, protection against catastrophic expenses, and a definitions section.
10. FEHB Facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-Service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-Service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services vary by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a Preferred provider organization (PPO) arrangement. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copayment of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level of benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90-day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the **High Option** Blue Cross and Blue Shield Service Benefit Plan premium will increase by 4.3% for Self Only or 3.6% for Self and Family.

Your share of the **Standard Option** Blue Cross and Blue Shield Service Benefit Plan premium will increase by 8.0% for Self Only or 7.2% for Self and Family.

We have eliminated the $50 prescription drug deductible applicable to drugs obtained from retail pharmacies under **both options**.

We no longer waive the copayment for prescription drugs obtained through the mail for members with Medicare Part B as primary payer. Under **High Option**, all members now pay $8 for generic and $14 for brand-name prescription drugs and supplies obtained through the Mail Service Prescription Drug Program. Under **Standard Option**, all members now pay $12 for generic and $20 for brand-name prescription drugs and supplies obtained through the mail. See pages 34-35.

Under **High Option**, we no longer waive or reduce the coinsurance for prescription drugs obtained from a retail pharmacy for members with Medicare Part B as primary payer, and all members will pay 15% PPA at Preferred retail pharmacies and 35% AWP at Non-preferred retail pharmacies. Previously, when Medicare Part B was the primary payer, the 15% PPA coinsurance at Preferred pharmacies was waived and the 35% AWP coinsurance at Non-preferred pharmacies was reduced to 15% AWP. See pages 34-35.

Under **Standard Option**, you now pay 25% PPA at Preferred retail pharmacies and 45% AWP at Non-preferred retail pharmacies. Previously, coinsurance was 20% PPA at Preferred retail pharmacies and 40% AWP at Non-preferred retail pharmacies. See pages 34-35.

Under **Standard Option**, we no longer waive or reduce the coinsurance for prescription drugs obtained from a retail pharmacy for members with Medicare Part B as primary payer who are confined to a nursing home. Previously, the 20% PPA coinsurance at Preferred retail pharmacies was waived and the 40% AWP coinsurance at Non-preferred retail pharmacies was reduced to 20% AWP. See pages 34-35.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. To be sure your claims are processed by this Carrier, you must submit the Medicare Summary Notice (MSN) and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare Summary Notice (MSN).

Claims should show both your Plan identification number (8 digits preceded by "R") and your Medicare identification number which is on your Medicare card. Claims for benefits which are not covered by Medicare should be sent directly to your Local Plan. See page 40 for information on how retail pharmacy-obtained drug expenses are filed.

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay for. After the first plan pays, we will pay either what is left of our allowable charge or our regular benefit, whichever is less. We will not pay more than our allowable charge. When we pay secondary, we will generally only make up the difference between the primary plan's benefit payment and 100% of our allowable charge, subject to our applicable deductibles, coinsurance and copayments (see pages 43-44 for exceptions when Medicare is primary payer). Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances when we are secondary, and there is no adverse effect on you, we may also take advantage of any provider discount arrangements the primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan. When we are secondary to primary coverage you may have from a prepaid plan, our benefits will be based on your out-of-pocket liability under the prepaid plan (generally the prepaid plan's copayment) subject to our deductibles, coinsurance, and copayments (see page 44 for exceptions.)

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

When others are responsible for injuries

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. We have the right to recover payments we have made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to our right of recovery, we are subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse us for benefits we paid in an amount not to exceed the amount of the recovery; and 2) that we will be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse us for benefits paid. Our share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless we agree in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, we shall have a lien on the proceeds of that claim in order to reimburse ourselves to the full amount of benefits we are called upon to pay. Our lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) we will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice our ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist us in any recovery; 2) our right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) we may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify us promptly of any third party claim that you may have for damages for which we have paid or may pay benefits. In addition, you are required to notify us of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse us to the extent of benefits paid by us. Any reduction of our claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by us.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Overpayments

We will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called **the equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the provider's agreement with the Local Plan specifies otherwise, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

Section 9. Fee-for-Service Facts

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and keep premiums under control by following the procedures specified in this subsection.

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500. When you call to obtain precertification, be sure also to verify whether the hospital is a Preferred, Member or Non-member hospital.

To precertify a scheduled admission:

- You, your representative, your physician, or your hospital must call the Local Plan prior to admission.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date, and phone number; reason for hospitalization, proposed treatment, or surgery; name of hospital or facility; name and phone number of admitting physician; and number of planned days of confinement.

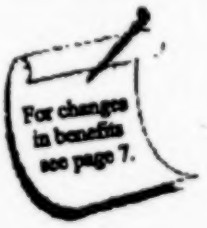
The Local Plan will then tell the physician and/or hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the certification decision will be sent to you, your physician, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Blue Cross and Blue Shield Service Benefit Plan

http://www.fepblue.org

2001

A fee-for-service plan with a preferred provider organization and a point-of-service product



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating local Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP

Enrollment codes for this Plan:

101 High Option - Self Only
102 High Option - Self and Family
104 Standard Option - Self Only
105 Standard Option - Self and Family

RI 71-005

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Introduction

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier).

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on pages 7 and 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan or the local Blue Cross and Blue Shield Plans that administer it.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure, or e-mail us at fehbwebcomments@opm.gov, or write to OPM at the Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own hospitals, physicians, and other professional health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at a reduced cost. Your Local Plan (or for retail pharmacies, PCS Health Systems, Inc.) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory. Contact your Local Plan to request a PPO directory.

PPO benefits apply only when you use a PPO provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

We also have Point-of-Service (POS) benefits:

In certain areas, our fee-for-service plan offers POS benefits to members who select Standard Option. This means you can get better benefits at less out-of-pocket costs by signing up with us for the POS program, selecting a contracted POS primary care physician (PCP), and letting the PCP manage your care. In Minnesota and North Dakota, you select a primary care clinic rather than a primary care physician. If you go to another provider without a referral from your PCP, we will provide only regular Standard Option non-PPO benefits. We offer the POS program in the following areas: Connecticut, Georgia, Kansas, Louisiana (New Orleans area), Massachusetts, Minnesota, New Jersey, New York (areas served by the Empire Plan), North Dakota (Fargo area), and Oklahoma. You can obtain a brochure addendum from your Local Plan in these areas that describes our POS service areas, benefit levels, and special requirements.

How we pay professional and facility providers:

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and non-physician health care professional providers in its service area, and is responsible for processing and paying claims for services you receive within that area. Most, but not all, of these contracted providers are in our PPO network.

- **PPO providers.** PPO providers have agreed to accept a specific negotiated amount as payment in full for services provided to you. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive services from PPO providers, and are limited to your applicable deductible, and coinsurance or copayments, for covered services. We provide benefits for some services (such as a routine physical exam) only when you use PPO providers.

- **Participating providers.** Some Local Plans also contract with other providers that are not in our PPO network. If they are professionals, we refer to them as "Participating" providers, and if they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our PPO providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our non-PPO benefit levels. Your out-of-pocket costs will be greater than if you use PPO providers.

  Note: Not all areas have participating providers and/or member facilities. To verify the status of a provider, please contact the Local Plan serving the area where the services are to be performed.

- **Non-participating providers.** Providers who are not PPO or Participating providers do not have contracts with us, and may or may not accept our allowance. We refer to them as "Non-participating providers" generally, although if they are facilities we may refer to them as "Non-member facilities." When you use Non-participating providers, you may have to file your claim with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance, in addition to any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use PPO or Participating providers.**

Note: In Local Plan areas other than those described below, PPO and Participating providers who contract with us will generally accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and any charges for noncovered services. **However, this may not apply when there is another source of payment besides you and us.** When you have other coverage (see Section 9), the following exceptions exist in our arrangements with PPO and Participating professional providers. Contact your Local Plan if you have questions about the amounts PPO and Participating providers may collect from you.

- In Arizona, when there is any other source of payment (whether we pay primary or secondary), PPO and Participating physicians are not obligated to accept our allowance as payment in full.
- In New York areas served by the Rochester Plan and in West Virginia, except when we pay secondary to other Blue Cross and Blue Shield coverage administered by the same Local Plan, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.
- In Pennsylvania and Utah, when we pay secondary, PPO physicians are not obligated to accept our allowance as payment in full unless we make a payment as the secondary payer.
- In Puerto Rico, when we pay secondary, PPO physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.
- In Montana, when we pay secondary, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.
- In Rhode Island, South Carolina, and Vermont, except when we pay secondary to other Blue Cross and Blue Shield coverage, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, and providers. You can also find out about care management, including medical practice guidelines, disease management programs, and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our website at www.fepblue.org.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example:

- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older
- Some people with disabilities, under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under the Original Medicare Plan, such as most prescription drugs.

When you are enrolled in this Plan and the Original Medicare Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 13 for exception).

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of the covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at the number on the back of your Service Benefit Plan ID card or visit our web site at www.fepblue.org.

We waive some costs when you have Medicare: When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

When Medicare Part A is primary, we will waive our:

- Inpatient hospital per-admission copayments;
- Inpatient Non-member hospital coinsurance; and
- Non-PPO inpatient per-day copayments for mental conditions/substance abuse care.

Note: Once you have exhausted your Medicare Part A benefits, we become primary. You must then pay any difference between our allowance and the billed amount at Non-member hospitals.

When Medicare Part B is primary, we will waive our:

- Calendar year deductible;
- Coinsurance for care by physicians and other health care professionals (inpatient and outpatient, including mental conditions/substance abuse care);
- PPO physician office visit copayments;
- PPO physician and facility copayments for routine physical examinations and preventive (screening) services; and

- Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions/substance abuse care.

Note We do not waive benefit limitations, such as the 25-visit limit on occupational and speech therapy visits.

You must tell us about your or your covered family members' Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart

A. When either you – or your covered spouse – are age 65 or over and ...	**Then the primary payer is...**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability)		
2) Are an annuitant		
3) Are a re-employed annuitant with the Federal government when...		
a) The position is excluded from FEHB, or.....		
b) The position is not excluded from FEHB.....		
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge)		
5) Are enrolled in Part B only, regardless of your employment status	(for Part B services)	(for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	(except for claims related to Workers' Compensation)	
B. When you - or a covered family member - have Medicare based on End Stage Renal Disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD		
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD		
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision		
C. When you - or a covered family member - have FEHB and...		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or.....		
b) Are an active employee.....		

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and Medicare Part B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles if you receive services from providers who do not participate in the Medicare managed care plan.

Suspended FEHB coverage and enrollment in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan, eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **Private contract**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by the Original Medicare Plan. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after the Original Medicare Plan's payment.

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- We will not reduce our share of any recovery unless we agree in writing to a reduction, (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,

Plaintiff,

- against -

DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH,

Defendant.

----------x

STATEMENT OF MATERIAL FACTS

CV # 03-CV-2728 (DC)

The defendant, DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH, by her attorneys, hereby sets forth a Statement of Material Facts, pursuant to Local Civil Rule 56.1(a), as to which she contends there are no genuine issues to be tried.

1. Plaintiff seeks to recover the sum of $157,309.06 in health benefits it claims were paid on behalf of JOSEPH E. McVEIGH during his life as the result of medical treatment he received for injuries in an accident that occurred in 1997. The defendant relies on the allegations contained in plaintiff's Verified Complaint.

2. JOSEPH E. McVEIGH died on November 9, 2001 and DENISE FINN McVEIGH was appointed Administratrix of his Estate by the Surrogates' Court of New York County. Defendant will produce a

Certified Death Certificate and Letters of Administration issued by the Surrogates' Court of New York County.

3. Plaintiff alleges that it is entitled to recover the benefits alleged in paragraph "1" herein from the Estate of JOSEPH E. McVEIGH. Defendant relies on plaintiffs' Verified Complaint.

4. The administration of the Estate of JOSEPH E. McVEIGH is still pending. There have been no decrees or orders issued by the Surrogate of New York County relative to the approval or compromise of any wrongful death or personal injury claims or actions brought on behalf of JOSEPH E. McVEIGH, nor has any formal or informal accounting been issued or directed. Defendant will testify to the status of the Estate administration.

DATED: Mineola, New York
June 3, 2003

STOCK & CARR, ESQS.

by: VICTOR A. CARR (7542)

Attorneys for Defendant

88 Second Street
Mineola, New York 11501
(516) 747-2478

MERIDIAN RESOURCE CORPORATION

Page: 1

Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314

Acc. Date: 5/19/1997
Case#: 271487

Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-066-0000000001-0000

Family Total: $ 157,309.06

These claims have been paid for the patient JOSEP MCVEIGH as of: 02/28/2003

First Date of Service	Last Date of Service	Provider Name	Diag Code	Diagnosis	Charged	Paid	ICN
09/11/1997	09/11/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$600.00	$27.79	80153492
10/06/1997	10/06/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$900.00	$275.88	80063001
10/13/1997	10/17/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$750.00	$360.00	80214430520
10/20/1997	10/20/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$150.00	$45.98	73493239
02/18/1998	07/30/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$34,200.00	$34,200.00	82323021
03/10/1998	04/30/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$17,550.00	$17,550.00	81315128 ←
08/03/1998	08/31/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$3,150.00	$3,150.00	82883014
10/01/1998	12/30/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$32,850.00	$32,850.00	90256985
01/04/1999	01/14/1999	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,700.00	$2,700.00	90256986
01/19/1999	01/19/1999	BROWN,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$450.00	$98.40	90474449060
02/02/1999	02/09/1999	BROWN,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,250.00	$1,326.00	90474449070
02/10/1999	02/15/1999	BROWN,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$1,350.00	$885.60	90474449080
03/02/1999	03/09/1999	BROWN,,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$900.00	$590.40	90954420560
03/10/1998	04/30/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$17,550.00	$17,550.00	81313128 ←
03/10/1998	04/30/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$17,550.00	$17,550.00	82186995 ←
09/01/1998	09/14/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,700.00	$2,700.00	82723004
09/17/1998	09/29/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,700.00	$2,700.00	82853098
04/24/1998	04/24/1998	BURCHELL,	99850	POSTOPERATIVE INFECTION	$675.00	$205.20	81394409130
03/27/1998	04/14/1998	BURCHELL,,	87920	WOUND/ABDOMINAL WALL,ANTERIOR /SIMPLE	$330.00	$175.00	81254406960
02/14/1998	02/14/1998	COYNE,	78400	HEADACHE	$85.00	$55.00	80964411060
02/24/1998	02/24/1998	COYNE,	78900	ABDOMINAL PAIN,ACUTE OR SEVERE	$85.00	$55.00	80754410270
03/17/1998	03/17/1998	COYNE,	78900	ABDOMINAL PAIN,ACUTE OR SEVERE	$55.00	$40.00	80794411200
12/11/1997	12/11/1997	COYNE, JOHN A	78900	ABDOMINAL PAIN,ACUTE OR SEVERE	$85.00	$55.00	736504774
06/12/1997	06/17/1997	FERBER,	51882	OTHER PULMONARY INSUFFICIENCY, NEC	$1,410.00	$353.40	81694408470
09/16/1998	09/16/1998	GROSS,	71946	JOINT PAIN-LEG	$335.00	$202.00	82654428340
09/16/1998	09/16/1998	GROSS,	71946	JOINT PAIN-LEG	$588.00	$303.65	82804412040
12/20/1999	12/20/1999	KATZ,	46200	ACUTE PHARYNGITIS	$574.00	$214.70	93818031690
06/01/2000	06/01/2000	KATZ,	38918	SENSORNEUR LOSS COMB TYP	$168.69	$42.06	01548052110
10/15/1997	10/15/1997	LIANG, HOWARD G	87920	WOUND/ABDOMINAL WALL,ANTERIOR /SIMPLE	$150.00	$112.50	730803765
09/30/1997	10/20/1997	NYU HOSPITALS CENTER	30030	OBSESSIVE-COMPULSIVE DIS	$22,545.04	$14,464.00	80880022050
03/23/1998	03/23/1998	NYUMCFPO,	38910	SENSORNEUR HEAR LOSS NOS	$1,650.00	$1,087.50	80964403450
10/03/1997	10/08/1997	NYURADIO,	78400	HEADACHE	$341.50	$156.60	81184442510
10/10/1997	10/10/1997	PACIA,	78030	CONVULSIONS	$130.00	$123.50	73373281
01/06/1998	06/15/1998	ROSENBLU,	78039	OTHER CONVULSIONS	$450.00	$315.60	82014443140

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Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314
Acc. Date: 5/19/1997
Case#: 271487
Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-088-0000000001-0000
Family Total: $ 157,309.06

These claims have been paid for the patient JOSEP MCVEIGH as of: 02/28/2003

01/08/1998	01/08/1998	ROSENBLU,	43790	CEREBROVASC DISEASE NOS	$300.00	$159.00	80204414680
02/16/1998	02/16/1998	ROSENBLU,	43710	AC CEREBROVASC INSUF NOS	$75.00	$40.00	80784429100
07/20/1998	07/20/1998	ROSENBLU,	43790	CEREBROVASC DISEASE NOS	$75.00	$40.00	82124429100
10/19/1998	10/19/1998	ROSENBLU,	78030	CONVULSIONS	$75.00	$40.00	83104401600
10/27/1998	10/27/1998	ROSENBLU,	43790	CEREBROVASC DISEASE NOS	$300.00	$129.20	83454416270
10/27/1998	10/27/1998	ROSENBLU,	78039	OTHER CONVULSIONS	$300.00	$235.60	83104403260
02/03/1999	02/03/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	90424407040
02/25/1999	02/25/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$300.00	$235.60	90634412810
03/10/1999	03/10/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	90774413310
05/20/1999	05/20/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$300.00	$235.60	91674416150
06/07/1999	06/07/1999	ROSENBLU,	78400	HEADACHE	$75.00	$38.00	91824411090
07/12/1999	07/12/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	92024410050
09/13/1999	09/13/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	92654168130
04/24/1998	04/24/1998	ST. VINCENTS HOSPITAL AND	99883	NON-HEAL SURGICAL WOUND	$783.00	$975.00	81419248650
06/11/1997	06/11/1997	STONYBRO,,	95990	INJ/NOS	$2,185.00	$1,638.75	83084404110
					$172,983.23	$156,439.51	

MERIDIAN RESOURCE CORPORATION

Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314

Acc. Date: 5/19/1997
Case#: 271487

Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-088-0000000001-0000

Family Total: $ 157,309.06

These claims have been paid for the patient DENIS MCVEIGH as of: 02/28/2003

First Date of Service	Last Date of Service	Provider Name	Diag Code	Diagnosis	Charged	Paid	ICN
12/03/1998	12/03/1998	COYNE,	72450	BACKACHE,UNSPEC	$65.00	$55.00	83484413660
12/16/1998	12/16/1998	LIRADIOL,	72210	DISPLCMNT/LUMBAR DISC W/O MYELOPATHY	$1,250.00	$380.00	90084418850
12/15/1998	12/15/1998	SHEBAIRO,	72440	THORACIC/LUMBOSACRAL NEURITIS UNSPEC	$200.00	$190.00	90274404780
					$1,515.00	$625.00	

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MERIDIAN RESOURCE CORPORATION

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Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314

Acc. Date: 5/19/1997
Case#: 271487

Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-088-0000000001-0000

Family Total: $ 157,309.06

These claims have been paid for the patient JOSEPH MCVEIGH as of: 02/28/2003

First Date of Service	Last Date of Service	Provider Name	Diag Code	Diagnosis	Charged	Paid	ICN
01/01/1900	01/01/1900		85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$103.48	$37.05	730004016
01/01/1900	01/01/1900		85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$150.00	$112.50	729602607
01/01/1900	01/01/1900	COYNE, JOHN A	85090	CONCUSSION/NOS	$125.00	$95.00	726605074
					$378.48	$244.55	

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(6)

Supreme Court, U.S.
FILED
FEB 24 2006
OFFICE OF THE CLERK

No. 05-200

In the Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC., DBA EMPIRE BLUE CROSS BLUE SHIELD, PETITIONER

v.

DENISE F. MCVEIGH, AS ADMINISTRATRIX OF THE ESTATE OF JOSEPH E. MCVEIGH

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether federal question jurisdiction exists over a suit by a federal government contractor to enforce a provision in a health benefits plan for federal employees that is part of a government contract under the Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.*

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In the Supreme Court of the United States

No. 05-200

EMPIRE HEALTHCHOICE ASSURANCE, INC., DBA
EMPIRE BLUE CROSS BLUE SHIELD, PETITIONER

v.

DENISE F. MCVEIGH, AS ADMINISTRATRIX
OF THE ESTATE OF JOSEPH E. MCVEIGH

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

Pursuant to the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C. 8901 *et seq.*, the United States enters into contracts with carriers to provide health benefits to federal employees, annuitants, and their dependents. The question presented in this case is whether there is federal jurisdiction over a suit by a FEHBA carrier against an enrollee to enforce a term of a FEHBA contract. The federal government has a substantial interest in the uniform enforcement of FEHBA contracts, in the costs of FEHBA, in the terms and conditions of federal employment, and in the welfare of federal employees. At the Court's invitation, the Solic-

itor General filed an amicus brief on behalf of the United States at the petition stage of this case.

STATEMENT

1. Congress enacted the Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.*, to establish a comprehensive program that would "assure maximum health benefits for employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 957, 86th Cong. 1st Sess. 4 (1959). Today, approximately eight million federal employees, retirees, and their dependents receive health insurance through plans under FEHBA, at a total cost of about $31 billion per year in premiums, $22 billion of which is paid by the federal government. *OPM Announces Smallest Average FEHB Premium Increase in Nine Years* (Sept. 15, 2005) <http://www.opm.gov/news/opm-announces-smallest-average-FEHB-premium-increase-in-nine-years,961.aspx>.

FEHBA confers broad authority on the Office of Personnel Management (OPM) to administer the Federal Employees Health Benefits Program, see 5 U.S.C. 8901-8913, and to promulgate regulations necessary to carry out the statute's objectives, see 5 U.S.C. 8913. The statute gives OPM authority to contract with carriers to offer health benefits plans to federal employees, annuitants, and dependents. 5 U.S.C. 8902, 8903. Such plans must meet criteria established by OPM, and each contract must contain "a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable." 5 U.S.C. 8902(d).

Federal employees may "elect to enroll or not to enroll within 60 days after becoming eligible." 5 C.F.R. 890.301(a); see 5 U.S.C. 8905(a). Employees enroll pursuant to the contract between the carrier and OPM, Pet. App. 3a n.1, and they are bound by the terms of that contract. See *Christiansen* v.

National Sav. & Trust Co., 683 F.2d 520, 530 (D.C. Cir. 1982). Each enrollee must be issued an "appropriate document" setting forth or summarizing the "(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder; (2) procedure for obtaining benefits; and (3) principal provisions of the plan affecting the enrollee and any eligible family members." 5 U.S.C. 8907(b).

By statute, the government and the enrollee share responsibility for premiums payable to the plan. 5 U.S.C. 8906 (2000 & Supp. II 2002). The employing agency (or OPM for annuitants) pays approximately 75% of the individual plan's premium as part of its payroll costs funded by general appropriations. 5 U.S.C. 8906(b)(1) and (2); 5 U.S.C. 8906(f) (Supp. II 2002). Premiums are deposited into a special fund called the Employees Health Benefits Fund (Fund) in the United States Treasury. 5 U.S.C. 8909(a).

Under the type of fee-for-service plan at issue in this case, the carrier draws against the Fund on a "checks-presented" basis to pay for covered health care services. 5 U.S.C. 8909(a); 48 C.F.R. 1632.170(b). Any balances in the Fund are not the property of the carriers. Rather, a carrier's profit, if any, comes from a negotiated service charge. See *National Ass'n of Postal Supervisors* v. *United States*, 21 Cl. Ct. 310, 315 (1990) ("The service charge is the only profit element of FEHBA. * * * [The] carrier may not make a profit on the premium charges themselves."), aff'd, 944 F.2d 859 (Fed. Cir. 1991); see also 48 C.F.R. 1615.902. Any surplus attributable to a plan may be used, at OPM's discretion, to reduce future government and employee contributions, increase plan benefits, or make a refund to the government and plan enrollees. 5 U.S.C. 8909(b); 5 C.F.R. 890.503(c)(2).

The government ultimately decides whether a claim for medical services should be paid under the program. 5 U.S.C.

8902(j). If a carrier denies payment of a claim, the plan enrollee or other covered individual may seek OPM review. 5 C.F.R. 890.105(a)(1). OPM's final determination regarding the claim is subject to judicial review in federal court under the Administrative Procedure Act, 5 U.S.C. 701, 706. See, *e.g.*, *Muratore* v. *OPM*, 222 F.3d 918, 920 (11th Cir. 2000).

FEHBA includes an express preemption provision, which states that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. 8902(m)(1). The provision was originally enacted "to establish uniformity in Federal employee health benefits and coverage." H.R. Rep. No. 282, 95th Cong., 1st Sess. 1 (1977). It was broadened in 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2366, "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," to "strengthen the case for trying FEHB program claims disputes in Federal courts rather than state courts," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 374, 105th Cong., 1st Sess. § 3, at 9 (1997).

2. The largest plan in the FEHBA program is the Blue Cross Blue Shield Service Benefit Plan. Pursuant to 5 U.S.C. 8902(a), OPM has entered into annual contracts with the Blue Cross Blue Shield Association, acting on behalf of petitioner and other participating local Blue Cross Blue Shield affiliates. The contract provides that "[b]y enrolling or accepting services under this contract, [enrollees and their eligible dependents] are obligated to all terms, conditions, and provisions of this contract." J.A. 90.

The contract also provides that "[t]he Carrier shall provide the benefits as described in the Certified Brochure Text

found in Appendix A," J.A. 89, and that "[t]he Carrier's subrogation rights, procedures, and policies, including recovery rights, shall be in accordance with the Certified Brochure Text," J.A. 100. The Certified Brochure Text is identical, other than in format, to the Statement of Benefits supplied to each enrollee. See 5 U.S.C. 8907(b). Indeed, the Certified Brochure Text recites that it "is based on text incorporated into the contract between OPM and [the carrier]." J.A. 128.

The Statement of Benefits has a reimbursement provision requiring plan participants to repay benefits if they receive compensation from a third party for an injury or illness for which benefits were paid.[1] If the participant does not voluntarily reimburse the plan, the contract requires the carrier to make a "reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention," and to "subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract," J.A. 95. Amounts received as reimbursement must be credited to the Treasury Fund, either through a cost reduction or a cash refund to the Fund. See 48 C.F.R. 31-201.5, 1631.201-70; see also C.A. App. A876-A877 ¶ 7.

---

[1] The provision states in relevant part:

> If another person or entity . . . causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:
>
> All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.

Pet. App. 4a.

3. Joseph E. McVeigh was an enrollee in the FEHBA plan administered by petitioner. McVeigh suffered injuries in an automobile accident in 1997 and received approximately $157,309 in FEHBA benefits prior to his death in 2001. In 2003, respondent Denise McVeigh (as administratrix of McVeigh's estate) recovered $3,175,000 in settlement of the estate's tort suit arising out of the accident. Pet. App. 3a.

When it learned of the settlement, petitioner sought reimbursement for the benefits it had provided to McVeigh. Respondent agreed to place $100,000 in escrow pending litigation. See Pet. App. 3a. In April 2003, petitioner commenced this action against respondent in the United States District Court for the Southern District of New York, seeking reimbursement of the $157,309 in benefits it had paid. See *ibid.* The complaint invoked the district court's federal question jurisdiction, alleging that the "action is founded on [FEHBA]; on federal contracts and regulations established pursuant to FEHBA; and on federal common law." J.A. 41. The complaint sought declaratory relief, a judgment for $157,309, and orders requiring respondent to pay the $100,000 in escrow and an additional $57,309 to petitioner. J.A. 47. The district court granted respondent's motion to dismiss the complaint for lack of subject matter jurisdiction. Pet. App. 54a-62a.

4. a. A divided panel of the court of appeals affirmed, holding that "[petitioner's] claims are breach-of-contract claims arising under state law." Pet. App. 24a. Because FEHBA does not provide an express statutory cause of action for a carrier suit against an enrollee, the court concluded that "federal jurisdiction exists over this dispute only if federal common law governs [petitioner's] claims." *Id.* at 5a. Citing and quoting *Boyle* v. *United Technologies Corp.*, 487 U.S. 500, 507 (1988), the court stated that federal common law governs only when "the operation of state law would (1) significant[ly] conflict with (2) uniquely federal interests." Pet. App. 6a.

The court did not dispute petitioner's contention that its reimbursement action "directly affects the United States Treasury and the cost of providing health benefits to federal employees." Pet. App. 6a. The court also did not dispute petitioner's contention that "Congress has expressed its interest in maintaining uniformity among the states with respect to the benefits of its health plans." *Ibid.* The court concluded, however, that petitioner failed to show that the operation of New York state law creates 'an actual, significant conflict' with those interests." *Id.* at 6a-7a. In the court's view, the fact that "uncertainties associated with the application of state law 'might'" impose fiscal costs on the federal government and the fact that "enrollees in some states 'might' successfully avoid reimbursement while others would have to repay" were "speculations" that "do not suffice to satisfy the conflict prong of *Boyle*." *Id.* at 7a.

The court also rejected the suggestion that federal question jurisdiction exists by virtue of FEHBA's preemption provision, 5 U.S.C. 8902(m)(1), which provides that "[t]he terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" preempt "any State or local law * * * which relates to health insurance or plans." Pet. App. 10a & n.5. The court found "highly problematic" constitutional difficulties were raised by the fact that Section 8902(m)(1)'s "plain language differs from typical preemption provisions by unambiguously providing for preemption by contract," rather than preemption by federal statutory or common law. *Id.* at 11a. The court concluded that Section 8902(m)(1) could be saved by narrowly construing it to require that "[t]he federal law preempting state law may be federal common law or the FEHBA statute provisions themselves, but it must be law—not contract terms." *Id.* at 14a.

The court's ultimate holding on preemption, however, did not concern any distinction under Section 8902(m)(1) between federal contract terms and federal statutory or common law. Instead, opining that "the presumption against federal preemption * * * should guide our analysis," Pet. App. 15a, the court offered a narrow view of the preemption provision in a different respect. Addressing the clause providing that Section 8902(m)(1) preempts only state laws that "relate[] to health insurance or plans," the court held that there was no showing that the dispute in this case "implicates a specific state law or state common-law principle" that "relate[s] to health insurance" under Section 8902(m)(1). *Id.* at 15a.

b. Judge Sack concurred, acknowledging that petitioner had "made a substantial showing that * * * this case implicates 'uniquely federal interests.'" Pet. App. 25a (quoting *Boyle*, 487 U.S. at 504). He suggested that if, in a future case, a carrier could identify significant ways in which state law would conflict with the policies underlying FEHBA, federal question jurisdiction would exist. See *ibid.*

c. Judge Raggi dissented. See Pet. App. 27a-45a. She explained that "FEHBA contracts are enforceable through common-law breach of contract actions." *Id.* at 29a-30a. In her view, because petitioner brought this action and in its pleadings "relies exclusively upon federal law," the court needed to decide "only whether federal common law does in fact govern claims to enforce rights under a FEHBA plan." *Id.* at 34a. She concluded that it does, explaining that FEHBA's preemption provision contemplates that the terms of a FEHBA plan "will uniformly be construed and enforced according to federal common law," *id.* at 44a.

5. Petitioner filed a petition for panel rehearing and rehearing *en banc*. In an amicus brief filed in support of the petition, the United States argued that federal jurisdiction exists in this case, both because the claim is based on a fed-

eral cause of action under the analysis in *Jackson Transit Authority* v. *Local Division 1285*, 457 U.S. 15, 22 (1982), and because federal law is in any event a "necessary element" of petitioner's claim, see *City of Chicago* v. *International Coll. of Surgeons*, 522 U.S. 156 (1997). Pet. App. 72a-76a.

In an opinion denying panel rehearing, the court acknowledged that the "critical factor" in the *Jackson Transit* analysis congressional intent. Pet. App. 48a. In the court's view, FEHBA's preemption provision "addresses the extent to which federal law will govern FEHBA-related claims" and establishes that state law controls. *Id.* at 48a-49a. The court also rejected the contention that federal law is a "necessary element" of petitioner's claim for relief, although the court provided no separate analysis of that point. *Id.* at 49a n.4. Finally, the court stated that its "discussion of the constitutional difficulties inherent in a literal reading of § 8902(m)(1) was not an essential component of [its] holding that § 8902(m)(1) does not authorize jurisdiction." *Id.* at 49a. The court stated that even if the provision "posed no constitutional concern," its analysis of the "relates to health insurance or plans" language "makes clear that the provision does not create jurisdiction here." *Id.* at 49a-50a. The court concluded that "[r]econsideration of the constitutional issue therefore could not affect the outcome of the case." *Id.* at 50a.

Judge Raggi noted that she would vote to grant rehearing for the reasons stated in her original dissent. Pet. App. 51a. The petition for rehearing *en banc* was denied without opinion. *Id.* at 52a-53a.

SUMMARY OF ARGUMENT

Under long-familiar principles, a case "arises under federal law" within the meaning of 28 U.S.C. 1331 if "a well-pleaded complaint establishes either that federal law creates the cause of action or that the plaintiff's right to relief neces-

sarily depends on resolution of a substantial question of federal law." *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 27-28 (1982). Under either of those alternatives, this case arises under federal law.

1. *Jackson Transit Authority* v. *Local Division 1285*, 457 U.S. 15 (1982), presented the question whether a suit to enforce a contract contemplated by a federal statute states a federal claim. The Court held that, if Congress intended "that the rights and duties contained in th[e] contracts be federal in nature," then suits to enforce them "state[] federal claims" and may be brought in federal court. *Id.* at 23.

Suits to enforce FEHBA contract terms may be brought in federal court, because Congress clearly intended the rights and duties in FEHBA contracts to be federal in nature. The government is a party to a FEHBA contract, and it has long been settled that construction of government contracts presents "questions of federal law not controlled by the law of any State." *United States* v. *County of Allegheny*, 322 U.S. 174, 183 (1944), limitation on other grounds recognized, *United States* v. *County of Fresno*, 429 U.S. 452, 462 n.10 (1978).

The structure of FEHBA leads to the same conclusion. The federal government has an overwhelming interest in attracting able workers to the federal workforce and, therefore, in the terms and conditions of federal employment, including the FEHBA program. The government has a similarly substantial interest in the health and welfare of the federal workers upon whom it relies to carry out its functions. In addition, the federal government has a direct financial interest in the operation of the FEHBA program and, specifically, in the reimbursement provisions of a FEHBA contract. Petitioner paid the benefits in this case out of a fund in the United States Treasury, and reimbursements are likewise credited to that fund. Indeed, because the carrier's profits are based solely on a negotiated service charge, the United States—and

not the carrier—is the sole beneficiary of a successful reimbursement action. FEHBA's preemption provision, which broadly preempts state laws that affect "benefits" or "payments with respect to benefits" under FEHBA, 5 U.S.C. 8902(m)(1), further reinforces the conclusion that Congress intended the rights and obligations under FEHBA contracts to be entirely federal in nature. Accordingly, there is federal jurisdiction over disputes concerning those rights.

II. Federal jurisdiction also lies in this case because, even if the Court concludes that it is necessary to look to state law to supply the cause of action, all elements of the claim on the merits are nonetheless federal in character. The case seeks to enforce the terms of a government contract whose construction and application is governed wholly by federal law.

Recognizing federal jurisdiction over suits to enforce the reimbursement or other provisions of FEHBA contracts would not disturb Congress's approved balance between state and federal judicial remedies. Congress should be presumed to be aware of the basic rule that the validity and construction of federal contracts present questions of federal law, and FEHBA's preemption provision confirms that understanding. Congress therefore would have assumed that federal courts would have jurisdiction over suits to enforce FEHBA contracts. Indeed, the congressionally approved federal-state balance would be upset by requiring suits to enforce FEHBA contracts to be litigated in *state* courts.

The federal issues are actually disputed and substantial. The case was decided on respondent's motion to dismiss petitioner's complaint. In those circumstances, unless the pleadings demonstrate a narrower scope of dispute, a court should assume that respondent disputes petitioner's assertions that federal law entitles it to relief. Moreover, all of the significant legal issues that could arise would likely involve the con-

struction and application of a FEHBA contract, and they would therefore present substantial questions of federal law.

ARGUMENT

I. A CARRIER'S SUIT FOR REPAYMENT OF FEHBA BENEFITS STATES A FEDERAL CLAIM

A. Under *Jackson Transit*, A Suit To Enforce A Contract Contemplated By A Federal Statute States A Federal Claim If Congress Intended The Contractual Rights And Duties To Be Federal In Nature

Where Congress has enacted a statute that contemplates the formation of contracts, this Court has explained that the question whether suits to enforce such contracts arise under federal law turns on whether Congress intended that the rights and duties arising from the contracts be federal in nature. If Congress intended that those rights and duties be federal, then a suit under the contract arises under federal law.

Under the statute at issue in *Jackson Transit Authority* v. *Local Division 1285*, 457 U.S. 15 (1982), a state or local government, as a condition of receiving federal assistance for acquisition of a private transit company, was required to make "fair and equitable arrangements * * * to protect the interests of employees affected by such assistance," including "the preservation of rights * * * under existing collective bargaining agreements." *Id.* at 17-18 & n.2 (quoting 49 U.S.C. 1609(c) (1976)). A local government that received federal funds for acquiring a private bus company entered into a contract with its employees under that provision. When the local government later attempted to terminate the contract, the union filed suit in federal court, alleging, *inter alia*, that the company had violated the federal statute and the collective-bargaining agreement. *Id.* at 19. The question presented was

whether there was federal jurisdiction over the union's claims. *Jackson Transit*, 457 U.S. at 19.

The Court concluded in *Jackson Transit* that, because the statute "contemplates" contracts between local governments and their unions, "it is reasonable to conclude that Congress expected [those contracts], like ordinary contracts, to be enforceable by private suit upon a breach." 457 U.S. at 20-21. The availability of a federal forum for such a suit, however, turned on whether the suit would be federal or state in nature—*i.e.*, "whether Congress intended" actions under the transit contracts "to set forth federal, rather than state, claims." *Id.* at 21; see *ibid.* ("precise question" is "whether the union's contract actions are federal causes of action").

The Court explained that the absence of an express cause of action in the statute does not establish that Congress intended to foreclose one, because "on several occasions the Court has determined that a plaintiff stated a federal claim when he sued to vindicate contractual rights set forth by federal statutes, despite the fact that the relevant statutes lacked express provisions creating federal causes of action." 457 U.S. at 22 (citing *International Ass'n of Machinists* v. *Central Airlines, Inc.*, 372 U.S. 682, 692 (1963) (a contract made pursuant to a federal statute "has * * * the imprimatur of the federal law upon it" and is therefore "enforceable by federal law, in the federal courts."); *Norfolk & W. R.R.* v. *Nemitz*, 404 U.S. 37 (1971); *Transamerica Mortgage Advisors, Inc.* v. *Lewis*, 444 U.S. 11, 18-19 (1979); *Mills* v. *Electric Auto-Lite Co.*, 396 U.S. 375 (1970); and *American Surety Co.* v. *Shulz*, 237 U.S. 159 (1915)). Those cases, the Court continued, "demonstrate that suits to enforce contracts contemplated by federal statutes may set forth federal claims and that private parties in appropriate cases may sue in federal court to enforce contractual rights created by federal statutes." *Jackson Transit*, 457 U.S. at 22. The "critical factor"

in determining whether such suits set forth federal claims is the "congressional intent behind the particular provision at issue." *Ibid.* If Congress intended that the contracts under the statute "be creations of federal law" and "that the rights and duties contained in those contracts be federal in nature," then suits under the contracts "state[] federal claims." *Id.* at 23. If not, such suits "present[] only state-law claims." *Ibid.*

Applying that analysis in *Jackson Transit* itself, the Court concluded that the contract was governed by state law. The court noted that "labor relations between local governments and their employees are the subject of a longstanding statutory exemption from the National Labor Relations Act" and that the transit funding statute "evinces no congressional intent to upset the decision in the National Labor Relations Act to permit state law to govern the relationships between local governmental entities and the unions representing their employees." 457 U.S. at 23-24. In addition, the Court's review of the legislative history of the transit statute made it "absolutely clear that [Congress] did not intend to create a body of federal law applicable to labor relations between local governmental entities and transit workers," *id.* at 27. The court thus held that the union's claim was not based on a federal cause of action, and that Congress had intended the contracts required by the transit funding statute "to be governed by state law applied in state court." *Id.* at 29.[2]

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[2] The Court observed that, strictly speaking, the district court had *jurisdiction* under 28 U.S.C. 1331 to hear the union's suit, because it alleged a violation of the agreement contemplated by the transit funding statute and prayed for relief under federal law, and because the union's asserted federal claims were not "wholly insubstantial and frivolous." 457 U.S. at 21 n.6 (quoting *Bell* v. *Hood*, 327 U.S. 678, 681 (1946)). "Thus," the Court concluded, "the District Court had jurisdiction for the purposes of determining whether the union stated a cause of action on which relief could be granted." *Ibid.* On similar reasoning, the district court had jurisdiction here. And for the reasons stated in the text, petitioner does have a cause of action under federal law.

B. Congress Intended That Rights And Duties Under FEHBA Contracts Be Governed By Federal Law

Under the *Jackson Transit* analysis, the rights and duties created by FEHBA contracts are federal in nature. That is generally true of rights and obligations under *any* contract to which the federal government is a party. It is particularly true of FEHBA contracts, given the paramount and pervasive federal interest in FEHBA and the lack of any evidence that Congress intended state law to play any role in defining FEHBA benefits or construing FEHBA contracts. While the statutory structure implicated by *Jackson Transit* included a clear contrary indication in the NLRA's "anti-preemption" provision for local governments, FEHBA includes an equally clear reinforcing indication in its preemption provision. An action to enforce a FEHBA contract thus sets forth a federal claim, and it arises under federal law.

1. It has long been settled that "[t]he validity and construction of contracts through which the United States is exercising its constitutional functions, their consequences on the rights and obligations of the parties, the titles or liens which they create or permit, all present questions of federal law not controlled by the law of any State." *County of Allegheny*, 322 U.S. at 183 (citing cases); *Clearfield Trust Co.* v. *United States*, 318 U.S. 363, 366-367 (1943); cf. *Boyle*, 487 U.S. at 504 ("[O]bligations to and rights of the United States under its contracts are governed exclusively by federal law."). A FEHBA contract is a federal contract through which the United States exercises its power to provide for a federal workforce to carry out its other constitutional functions. A FEHBA contract therefore addresses the "uniquely federal interests," *ibid.*, in the relationship between the United States and its employees, through whom the United States pursues its fundamental "interest in getting the Govern-

ment's work done," *id.* at 505. Moreover, the reimbursement clause at issue here inures directly to the benefit of the Treasury. Accordingly, the rights and duties created by a FEHBA contract "present questions of federal law not controlled by the law of any State." *Allegheny County*, 322 U.S. at 183. Although Congress could provide that state law governs particular rights and duties under a federal contract, it has not done so here.

2. An examination of the FEHBA program reinforces the distinctly federal nature of the rights and duties under a FEHBA contract. Because the government's ability to hire and retain employees is a prerequisite to its ability to carry out all of its other constitutional functions, the establishment, organization, and governance of the federal workforce is a core function of the federal government. The federal government has a self-evident interest in the terms and conditions of federal employment, because it depends on attracting able employees to the federal workforce. Moreover, FEHBA contracts serve to maintain the health of the federal workforce. The federal government has a great interest in the health and welfare of those upon whom it relies to carry out its functions.

The FEHBA program was established to serve those interests. It was designed as a part of the compensation package offered to federal employees, in an effort to "bring the Government abreast of most private employers" and to "improv[e] the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel." H.R. Rep. No. 957, 86th Cong. 1st Sess. 2 (1959). It was also based on a "recognition on the part of the public that both basic health and major medical insurance coverages are essential to protect wage-earners and their families." *Id.* at 2. FEHBA's ultimate goal is "to facilitate and strengthen the administration of the activities of the government generally." *Id.* at 1.

The mechanics of the FEHBA program also reflect the strength and pervasiveness of the federal interest. Benefit payments derive from accounts that are funded and administered by the United States and maintained on the books of the United States Treasury. See p. 3, *supra*. Benefit determinations under the plans established by the contracts between OPM and carriers are made by the carrier in the first instance, but are subject to administrative review by OPM and to judicial review in an APA action against OPM, not a suit against the private carrier. See pp. 3-4, *supra*. In promulgating regulations in 1995 to clarify the administrative and judicial procedure for review of claims, OPM explained that "[h]ealth insurance contracts under the FEHB Program are federal contracts under 5 U.S.C., Chapter 89," and that, "[a]ccordingly, legal actions concerning disputes arising or relating to those contracts are controlled by federal, rather than State law." 60 Fed. Reg. 16,037 (1995).

The federal government has a direct interest in any action brought by the United States or a carrier to enforce the contract, particularly a reimbursement action like this case. Any repayment of benefits pursuant to a reimbursement clause such as the one at issue in this case must be credited to the Treasury account. FEHBA carriers have no property interest in any balance remaining in the Treasury fund after benefits are paid out and reimbursements received. Any surplus may be used by the government, at OPM's discretion, to lower future rates, reduce future government and employee contributions, increase plan benefits, or make a refund to the government and plan enrollees. See p. 3, *supra*. Accordingly, the carrier has no direct stake in a reimbursement suit, although it fulfills a contractual obligation to the government. The proceeds of the suit belong to the United States.

In short, there is a strong federal connection with and interest in all aspects of the FEHBA program. Those fea-

tures strongly reinforce the applicability of the general rule that the rights and obligations created by contracts entered into by the federal government are federal in nature. Under the *Jackson Transit* analysis, a suit to enforce a term in a FEHBA contract therefore states a federal claim.

3. Although the United States is not a party to this suit, petitioner's claim plainly seeks to enforce a term in a FEHBA contract. FEHBA carriers are obligated under their contracts with the government to provide health benefits to FEHBA enrollees and their eligible dependents. See Pet. App. 3a n.1. Conversely, FEHBA enrollees and those who accept FEHBA benefits are subject to the conditions on those benefits stated in the contract between the carrier and the government. See J.A. 90 ("By enrolling or accepting services under this contract, [participants] are obligated to all terms, conditions, and provisions of this contract."); see also Restatement (Second) of Contracts § 309 cmt. (c) (1979) ("The conduct of the beneficiary, * * * like that of any obligee, may give rise to claims and defenses which may be asserted against him by the obligor.").[3] One of the condi-

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[3] The right to reimbursement that petitioner seeks to enforce arises from the FEHBA contract. The most accurate way to describe the relationship between the parties is that the FEHBA participant is a third-party beneficiary of the FEHBA contract, and his conduct in enrolling in FEHBA or accepting FEHBA benefits has subjected him and his eligible dependents to the reimbursement condition. Alternatively, however, the same result would follow if (a) the participant were viewed as having entered into an independent contract, committing him to make reimbursement, when enrolling in a FEHBA plan or accepting benefits, or (b) the action is viewed as an action for restitution (legal and/or equitable) for sums withheld in violation of the terms of the FEHBA contract, see *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204, 213 (2002); *County of Allegheny*, 322 U.S. at 183 ("the titles *or liens* which [federal contracts] create or permit * * * present questions of federal law") (emphasis added). Cf. *Sereboff* v. *Mid-Atlantic Medical Servs., Inc.*, No. 05-260 (to be argued Mar. 28, 2006). For present purposes, what is important

tions to which participants are subject is the reimbursement provision, which requires that all tort recoveries "must be used to reimburse [the carrier] in full for benefits [the carrier] paid." Pet. App. 4a. And the carrier is obligated under the FEHBA contract to pursue reimbursement claims against participants, although the direct benefits of any recovery flow to the United States. See J.A. 19. Because this case is a suit to enforce provisions in the FEHBA contract between OPM and the carrier, petitioner's complaint states a federal claim.

C. FEHBA's Preemption Provision Confirms That Federal Law Governs This Suit

1. Congress's intent that rights and duties under a FEHBA contract be federal in nature is strongly reinforced by FEHBA's preemption provision, 5 U.S.C. 8902(m)(1). As its history makes clear, see p. 4, *supra*, Section 8902(m)(1) was designed to ensure that "[f]ederal employees in different states would [not] have different reimbursement obligations and hence different net benefits," a result that would be "contrary to the uniformity goal of FEHBA in general and its preemption provision in particular." *Blue Cross & Blue Shield* v. *Cruz*, 396 F.3d 793, 799 (7th Cir. 2005), petition for cert. pending, No. 04-1657; see Pet. App. 34a-44a (Raggi, J., dissenting); *Botsford* v. *Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390, 394 (9th Cir. 2002).

Section 8902(m)(1) mandates that FEHBA contract provisions that "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. 8902(m)(1). By virtue of Section 8902(m)(1), any state law that purports to limit, expand, or in

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is that Congress intended that the provisions in a federal FEHBA contract be enforceable, and this is an action to enforce them.

any way affect coverage or benefits (or payments with respect to benefits) under FEHBA plans is preempted. Even apart from the fact that state law concerning the reimbursement issue would be preempted by this provision, the preemption provision reinforces the pervasively federal nature of the underlying contracts for purposes of the *Jackson Transit* analysis. But there is no doubt that the reimbursement provisions of FEHBA contracts in particular have preemptive force under Section 8902(m)(1), and their preemptive force displaces state laws that would affect the right to reimbursement. FEHBA contract terms that require reimbursement "relate to the * * * extent of coverage or benefits" (because they limit benefits by requiring reimbursement from any tort recovery) and they specifically "relate to * * * payments with respect to benefits" (because they require such payments to be returned to the carrier under the specified circumstances). Any state laws that would affect reimbursement rights "relate to health insurance or plans," because they would affect the plan's rights to reimbursement under the FEHBA contract. Cf. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990) (state statute barring subrogation or reimbursement from claimant's tort recovery, is covered by ERISA's preemption clause, 29 U.S.C. 1144(a), because it "relate[s] to" ERISA plan).

Because there can be no state law to apply, it follows that reimbursement must be governed by *federal* law, including FEHBA itself, the terms of the FEHBA contracts, and federal common law where necessary to fill in the interstices. In short, Section 8902(m)(1) unambiguously confirms that the rights and obligations under FEHBA contracts are governed by federal law. Under *Jackson Transit*, that is sufficient to establish that a suit to enforce those rights or obligations states a federal claim. The preemption provision reinforces the federal nature of those suits, just as the "anti-preemp-

tion" policy of the NLRA pointed in the opposite direction in *Jackson Transit*.

2. The court of appeals committed two errors in addressing Section 8902(m)(1). First, it misapprehended the significance of Section 8902(m)(1) in this case. Second, its statement that the provision is "highly problematic, and probably unconstitutional," Pet. App. 11a, is erroneous.

a. The court misapprehended the significance of Section 8902(m)(1) in stating that "[w]ithout any showing that the dispute [in this case] implicates a specific state law or state common-law principle 'relat[ing] to health insurance,' § 8902(m)(1) does not authorize federal preemption of state law in this case." Pet. App. 15a. Here, Section 8902(m)(1) *categorically* ousts state law in the field of health insurance or plans, leaving no state law to apply.

Moreover, the *Jackson Transit* analysis does not turn on whether the plaintiff can identify a particular provision of state law that would be applicable to a particular federal contract and would be preempted. Instead, under *Jackson Transit*, the existence of a federal claim turns on whether Congress intended that "the rights and duties contained in * * * contracts [contemplated by FEHBA] be federal in nature." 457 U.S. at 23. The breadth of Section 8902(m)(1) confirms what would follow in any event from an analysis of the rest of the FEHBA scheme: that the federal interest in rights and duties under FEHBA contracts is predominant and pervasive, that there is nothing to suggest that Congress intended state law to have any role in the FEHBA scheme, and that the rights and duties under FEHBA contracts—especially rights and duties having to do with benefits and payments with respect to benefits—are therefore "federal in nature."

The court of appeals recognized that this Court has construed the term "relates to" in other preemption provisions "quite broadly." Pet. App. 18a. See, *e.g.*, *Ingersoll-Rand Co.*

v. *McClendon*, 498 U.S. 133, 139 (1990) (concluding in ERISA case that "a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect"); *Morales* v. *TWA*, 504 U.S. 374, 383 (1992) (concluding that words "relating to" in the Airline Deregulation Act of 1978, Pub. L. No. 95-504, 92 Stat. 1705, "express a broad pre-emptive purpose"). The court concluded, however, that it should adopt a narrower interpretation of FEHBA's preemption provision, see Pet. App. 19a-20a, thus leaving more scope for state law under FEHBA. That was error. ERISA regulates the benefits plans that private employers offer their employees. FEHBA governs the health benefit plans that the federal government provides its own employees. It is exceedingly unlikely that Congress intended a broader role for state law in the case of federal employees, relative to private employees.

b. As to the court's constitutional doubts, there is no basis for any doubt about the constitutionality of Section 8902(m)(1) when it is given the comprehensive construction its express terms require.[4] FEHBA is a valid exercise of Congress's power under the Spending Clause, U.S. Const. Art. I, § 8, Cl. 1, to provide for the maintenance of the Federal Government itself, as well as its power under the Necessary and Proper Clause, Art. I, § 8, Cl. 18. A FEHBA contract is a government contract, made pursuant to federal statute and regulations. Congress may provide that state law has no role in the

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[4] It was in any event inappropriate for the court to address questions about the constitutionality of a federal statute in a case where the court's result in the end did not hinge on those doubts or their resolution. See Pet. App. 49a-50a; *United States* v. *Raines*, 362 U.S. 17, 21 (1960); *Ashwander* v. *TVA*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring) ("[I]f a case can be decided on either of two grounds, one involving a constitutional question, the other a question of statutory construction or general law, the Court will decide only the latter").

construction or application of such a contract. *M'Culloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 427 (1819) ("It is the very essence of supremacy * * * to modify every power vested in subordinate governments, as to exempt its own operations from their own influence."). Indeed, it is long established that the terms of a government contract may be governed by federal common law (and thus displace state law) just as surely as if those terms were reflected in a statute or regulation. See, *e.g.*, *Boyle*, 487 U.S. at 512 (finding preemption based on conflict between state law and the terms of a federal procurement contract); *County of Allegheny*, 322 U.S. at 183 (holding that the terms of a federal contract under which machinery in a private factory would be property of the United States preempted state laws under which factory owner would have been found to own the machinery).

D. Neither The Result In *Jackson Transit* Itself Nor The Result In *Miree* v. *DeKalb County* Supports The Court Of Appeals' Holding

1. The Court's holding in *Jackson Transit* itself, that the contract between the municipality and the union in that case was governed by state law, casts no doubt on the conclusion that a FEHBA contract is governed by federal law. First, although the federal funding statute in *Jackson Transit* required the formation of the contract as a condition of receiving funds, the federal government itself was not a party to the contract. The federal government is a party to a FEHBA contract. Second, the result in *Jackson Transit* turned on an "anti-preemption" provision in a separate statute making clear Congress's intent that contracts between municipalities and their unions should be governed by state, not federal, law, and on legislative history showing clearly that state law should govern. There is no federal law or legislative history demonstrating that Congress intended that the rights and

duties under FEHBA contracts should be governed by state, not federal, law; to the contrary, the preemption provision in FEHBA itself makes it clear that such contracts are governed by federal law, and the legislative history of that provision shows that it was enacted to promote uniformity under national benefit plans and "to strengthen the case for trying FEHB program claims disputes in federal courts rather than State courts." H.R. Rep. No. 374, *supra*, at 9. Finally, the federal government's ongoing interests in most of the rights and duties created by the contract between the municipality and the union in *Jackson Transit* were minimal. The federal government's interests in the rights and duties created by a FEHBA contract—and in their uniform application throughout the country—are predominant and pervasive. Indeed, the federal government, not the carrier, would be the direct beneficiary of any recovery in the suit.

2. In its opinion on the petition for rehearing, the court of appeals also sought support (Pet. App. 49a) in this Court's decision in *Miree* v. *DeKalb County*, 433 U.S. 25, 30 (1977). In that case, a contract between the Federal Aviation Administration (FAA) and the County required the County to restrict land adjacent to an airport to uses compatible with airport operations. Certain parties who were the victims of an airplane accident sued the County in a diversity action in federal court, alleging that the accident was caused by the County's breach of the provision in its contract with the FAA and that they were third-party beneficiaries entitled to enforce that provision. This Court held that state law, not federal law, governed the question "whether private parties may, as third-party beneficiaries, sue a municipality for breach of the FAA contracts." *Id.* at 32.

Miree does not support the court of appeals' holding here. *Miree* involved only the "narrow" question, 433 U.S. at 29, whether state or federal law governed the question of third-

party beneficiary status in a diversity case otherwise properly brought in federal court, where the federal contract said nothing about any such beneficiary. By contrast, this case involves enforcement for the benefit of the United States of a right to reimbursement from a third-party beneficiary that is an express provision in a FEHBA contract and that implicates the core subject matter of the contract. In addition, the Court concluded in *Miree* that "[t]he operations of the United States" would not "be burdened or subjected to uncertainty" by "variant state-law interpretations" on the narrow question of third-party beneficiary status. *Id.* at 30. Indeed, the Court relied on the fact that resolution of that question would "have no direct effect upon the United States or its Treasury." *Id.* at 29. By contrast, the "operations" and financial interests of the United States are closely tied to the uniform construction and application of the rights and duties created by FEHBA contracts—and, in particular, to the reimbursement provisions in those contracts. Although the government's interests in *Miree* were "too speculative" and "far too remote * * * to justify the application of federal law," *id.* at 32-33, the government's interests in the rights and duties created under FEHBA contracts and their reimbursement provisions are direct, clear, and substantial. They are far more than sufficient to require the application of federal law.

II. FEDERAL LAW IS A NECESSARY ELEMENT OF THE CARRIER'S CLAIM.

Although "federal-question jurisdiction is invoked by and large by plaintiffs pleading a cause of action created by federal law," there is "another longstanding, if less frequently encountered, variety of federal 'arising under' jurisdiction." *Grable & Sons Metal Prods., Inc.* v. *Darue Eng'g & Mfg.*, 125 S. Ct. 2363, 2366-2367 (2005). Thus, "a claim arises under federal law if federal law provides a necessary element of the

plaintiff's claim for relief." *Jones* v. *R.R. Donnelley & Sons Co.*, 124 S. Ct. 1836, 1842 (2004). In *Grable*, for example, the Court explained that where "a state-law claim necessarily raise[s] a stated federal issue, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities," then federal jurisdiction is warranted. 125 S. Ct. at 2368. See *City of Chicago* v. *International Coll. of Surgeons*, 522 U.S. 156 (1997); *Merrell Dow Pharms., Inc.* v. *Thompson*, 478 U.S. 804, 808-809 (1986); *Smith* v. *Kansas City Title & Trust Co.*, 255 U.S. 180 (1921). Petitioner's claim for reimbursement arises under federal law on this basis as well.

1. Even if this Court determined that petitioner's claim is not based on a federal cause of action, it nonetheless would necessarily raise a federal issue. Petitioner's complaint attempts to enforce the reimbursement provision in petitioner's contract with the government; it invokes a federal statute (FEHBA), a federal contract, and federal common law. Any question concerning the interpretation or application of the reimbursement provision necessarily presents a question of federal law. That is because, as explained above, the validity and construction of a federal contract necessarily present questions of "federal law not controlled by the law of any State." *County of Allegheny*, 322 U.S. at 183. Any divergence from that time-honored principle in this case would not be warranted, because, as also explained above, the federal government has an overriding interest (and the States have no interest) in the FEHBA program and in its uniform application across the country. Further, the pervasive federal interest in matters arising under FEHBA contracts is expressly confirmed by FEHBA's preemption provision, which establishes that state law has no role in resolving questions

about benefits and payments for benefits under the FEHBA program. See pp. 15-18, 19-22, *supra*.

2. Recognizing federal jurisdiction in this case would not "disturb[] any congressionally approved balance of federal and state judicial responsibilities." *Grable*, 125 S. Ct. at 2363. Congress has never suggested that FEHBA contract disputes should be litigated in state court, and there is no longstanding history of state-court resolution of FEHBA disputes. To the contrary, Congress should be presumed to have been aware of the settled principle that federal contracts are construed and applied in accordance with federal law, and FEHBA's preemption provision confirms that understanding. Congress therefore would have assumed that federal courts would be open to suits under FEHBA contracts, and indeed that was one of the reasons for the expansion of the preemption provision in 1998. See p. 4, *supra*.[5]

This case is also poles apart from *Merrell Dow Pharmaceuticals Inc.* v. *Thompson*, 478 U.S. 804 (1986), in which recognizing federal jurisdiction would have disturbed the federal-state balance intended by Congress. See *Grable*, 125 S. Ct. at 2369-2370. In *Merrell Dow*, the Court held that federal jurisdiction did not lie over plaintiff's state-law tort claim against a drug company alleging that the firm's violation of federal misbranding prohibitions constituted negligence per

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[5] It is true that Congress did not create an express cause of action for reimbursement under FEHBA. Cf. 5 U.S.C. 8912 (granting federal courts jurisdiction "of a civil action or claim *against the United States* founded on" FEHBA) (emphasis added). But that is insufficient to defeat federal jurisdiction; the same was true in *Grable* itself, where Congress had similarly created a cause of action against the federal government to quiet title, but had not expressly provided for such an action between private parties. See 125 S. Ct. at 2369 n.4; cf. *Verizon Md., Inc.* v. *Public Serv. Comm'n*, 535 U.S. 635, 643 (2002) ("The mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others.") (quoting *Abbott Labs* v. *Gardner*, 387 U.S. 136, 141 (1967)).

se under state law. In that case, the application of federal law to resolve the case was not the product of any decision by *Congress*; rather, state common law simply borrowed federal standards. As the Court explained in *Grable*, *Merrell Dow* viewed "the combination of no federal cause of action and no preemption of state remedies for misbranding as an important clue to Congress's conception of the scope of jurisdiction to be exercised under § 1331." *Id.* at 2370. Indeed, "[a] general rule of exercising federal jurisdiction over state claims resting on federal mislabeling and other statutory violations would * * * have heralded a potentially enormous shift of traditionally state cases into federal courts." *Id.* at 2370-2371.

In *Merrell Dow*, Congress's failure to preempt state-law actions based on a misbranding theory indicated Congress's intent that such actions should proceed essentially as state-law suits in state courts. By contrast, in this case Congress's enactment of Section 8902(m)(1) broadly to preempt any state law applicable to health insurance or plans establishes that Congress did *not* intend that actions concerning rights and duties under FEHBA contracts should proceed essentially as state-law actions in state court. Similarly, while recognizing federal jurisdiction in *Merrell Dow* would have caused a huge shift of cases traditionally litigated in state court into federal court, there is no substantial tradition of enforcing reimbursement (or any other) provisions in FEHBA contracts in state court. Thus, to require litigation about rights and duties under FEHBA contracts to be conducted in *state* court would upset the federal-state balance that Congress intended.

3. The federal issues in this case are "actually disputed and substantial" within the meaning of *Grable*. Respondent has not yet filed an answer in this case, because respondent successfully moved to dismiss the complaint before the answer was due. In those circumstances, it should be assumed as a general matter under *Grable* that respondent disputes all

of the elements necessary for petitioner to prevail; otherwise, a party could always obtain a dismissal of a case on jurisdictional grounds, so long as it had not yet filed an answer or other pleading indicating the scope of the actual dispute. Accordingly, unless the pleadings demonstrate that the defendant has limited the dispute to issues solely of state law, a court should ordinarily assume that a complaint that bases its right to relief on application of federal law presents questions of federal law that are "actually disputed."

Even if state law provides the bare cause of action, federal law would overwhelmingly predominate. This is not a case like those discussed in *Grable*, in which there is some present dispute about title to land that would otherwise be governed entirely by state law, and in which the sole potential federal issue in the particular case involves the federal statutes under which the title was originally granted decades previously by the United States. 125 S. Ct. at 2369 n.3 (citing *Shulthis* v. *McDougal*, 225 U.S. 561 (1912)). In that situation, concerns about transforming a broad range of what are fundamentally state-law cases into federal cases has led the Court to impose the "actually disputed and substantial" limitation to ensure that the suit is genuinely federal in character.

No such concerns are present here. Even if state law provided the bare cause of action, all of the significant legal issues that could arise would likely involve the construction and application of a FEHBA contract provision, which would necessarily present questions of federal law. Courts addressing reimbursement questions in other cases have had to decide such issues as the scope of the reimbursement obligation and extent, if any, to which the reimbursement should take account of attorney's fees expended by participant to obtain the tort recovery. See, *e.g.*, *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, cert. granted, No. 04-1506 (Sept. 27, 2005). Those types of questions, which are likely to predomi-

nate in a case such as this, present substantial issues of federal law.

Furthermore, this is not a context in which factual issues are likely to predominate. The potential factual questions in this case would have to do with the amount of FEHBA benefits paid and the amount of tort recovery McVeigh actually received. There is no reason to believe that either of those relatively easily ascertainable figures is likely to be the subject of any significant dispute. But even if there is such a factual dispute in a particular case—and even if there is no dispute about the interpretation of federal law or the FEHBA contract in the case—federal jurisdiction is proper because the factual issues arise in the application of the federal contract, the suit seeks to recover benefits whose payment in the first instance is governed by federal law, the suit is pervasively federal in character on the merits, and the direct financial and other interests of the United States in the dispute make it especially appropriate that the courts of the United States should be open to its resolution. Cf. 28 U.S.C. 1345.

In short, permitting such cases to proceed in federal court is consistent with the paramount federal interest in the FEHBA program. Thus, even assuming that such claims are not based on a federal cause of action, recognizing federal jurisdiction is consistent with "the commonsense notion that a federal court ought to be able to hear claims recognized under state law that nonetheless turn on substantial questions of federal law, and thus justify resort to the experience, solicitude, and hope of uniformity that a federal forum offers on federal issues." *Grable*, 125 S. Ct. at 2367.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
d/b/a EMPIRE BLUE CROSS BLUE SHIELD,

Petitioner,

v.

DENISE FINN McVEIGH, as administratrix of the
Estate of JOSEPH E. McVEIGH,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF FOR AMICUS CURIAE JULIA CRUZ, AS REPRESENTATIVE OF JOSE S. CRUZ, IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether this Court should expand the Federal Employees Health Benefits Act's jurisdictional provision, 5 U.S.C. § 8912, to include reimbursement claims brought by private insurers against insureds arising under the terms of private contracts issued to federal employees, where the dispute arises from a tort recovery obtained by the insured in state court, where the contract terms at issue do not involve health coverage or benefits, where there is no demonstrated conflict between federal and state law on the issue, and where resolution of the claim does not substantially turn on interpretation of federal law.

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INTEREST OF AMICUS CURIAE

The law firm of Krislov & Associates, Ltd. is counsel to Petitioner, Julia Cruz, as Representative of Jose S. Cruz, in the petition pending before this Court in *Cruz v. Blue Cross Blue Shield of Illinois et al.*, No. 04-1657. The Seventh Circuit's decision in the *Cruz* case created a circuit split with the Second Circuit's decision being reviewed here. *Empire Healthchoice Assurance, Inc. v. McVeigh*, 402 F.3d 107, 110 (2d Cir. 2005) ("we note our disagreement with the conclusions reached in [*Cruz*], which the Seventh Circuit decided ten days after we issued our original decision"). Cruz and her counsel thus have a direct and substantial interest in the outcome of this case.

Record counsel for both Petitioner and Respondent have consented to the request of the Krislov firm, on behalf of Mrs. Cruz, to file an Amicus brief. This brief is filed in support of Respondent to assist in explaining why Petitioner's and the Government's arguments cannot be squared with congressional intent, this Court's jurisprudence, or federalism concerns. The Krislov firm, as *amicus curiae*, asks the Court to hold that Blue Cross's reimbursement claim does not arise under federal law and affirm the Second Circuit's decision holding that no federal subject matter jurisdiction exists over that claim.[1]

STATEMENT OF THE CASE

In this case, as in many others, a beneficiary of a federal government-sponsored medical plan, covered by the Federal Employees Health Benefits Act of 1959 ("FEHBA"), 5 U.S.C. §8901 *et seq.*, was injured in an accident. The FEHBA Plan, administered here by Empire HealthChoice Assurance, Inc., d/b/a Empire Blue Cross Blue Shield ("Petitioner" or "Blue

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1. No counsel for any party authored any portion of this brief. No party other than *amicus curiae* or their counsel made a monetary contribution to the preparation or submission of this brief.

Cross"), paid his medical expenses.[2] The beneficiary filed and pursued a state-court tort action against tortfeasors to recover damages. Neither the FEHBA Plan nor its representatives assisted or participated in the state-court action. Instead, Petitioner initiated a second action, in federal court, invoking a reimbursement provision contained in the Statement of Benefits document prepared and issued by Blue Cross to beneficiaries, to demand payment from the injured beneficiary of the amount the Plan had expended for his medical care.

The nature of reimbursement claims, such as Blue Cross's here, is that they attach to third-party recoveries obtained through the efforts and expense of others, such as Respondent. The tortfeasor's money, not Blue Cross's or the Government's, is at issue. Had Respondent not pursued the third-party tort action, Blue Cross would have been unable to assert its reimbursement right and would, instead, have had to resort to either its subrogation right (requiring Blue Cross to expend its own effort and expense for recovery) or forgo any recovery. Additionally, Blue Cross's reimbursement claim by definition must arise long after an insureds' coverage and benefit determinations have been resolved and benefit payments made. Notably, a substantial source of those benefit plan payments (at least 25% of all premium dollars) are derived from the insured. Thus, the reimbursement claim is, in part, recovering funds that originated from the insured.

Blue Cross rejected offers to resolve its reimbursement claim in Respondent's state court litigation, instead opting to file the case below. The district court granted Respondent's motion to dismiss, holding that federal subject matter

2. According to a December 2002 report by the United States General Accounting Office, approximately 8.3 million individuals were covered by FEHBA-governed health plans. Federal Employee's Health Plans, *Premium Growth and OPM's Role in Negotiating Benefits*, December 2002, *www.gao.gov/new.items/d03236.pdf*, p.1 (visited March 30, 2006) (the "GAO's December 2002 FEHBA Premium Growth Report").

jurisdiction does not exist over Blue Cross's reimbursement claim. The Second Circuit affirmed and denied Blue Cross's motions for rehearing and *en banc* review.

SUMMARY OF ARGUMENT

Blue Cross has been the Government's sole insurance carrier under the Service Benefit Plan since FEHBA's inception in 1959. Over the past forty years there have been numerous reimbursement claims asserted by Blue Cross and addressed, adjudicated, and resolved by state courts. Despite that long history, Blue Cross and the Government fail to present to this Court any evidence supporting their contention that state adjudication of these claims adversely affects the federal treasury, that state law significantly conflicts with these claims, that state courts, who are experienced and capable of resolving contract disputes and reimbursement claims, cannot adequately protect Blue Cross's interests, or that Congress has any concern about this issue.

Blue Cross and the Government do not contend that the FEHBA statute addresses reimbursement. Indeed, they do not even point to a stray remark about reimbursement anywhere in FEHBA's legislative history. Nor do they contest that the Office of Personnel Management ("OPM"), which is authorized to "prescribe regulations necessary to carry out [FEHBA]", 5 U.S.C. § 8913, has not issued regulations addressing reimbursement. Blue Cross fails to support its position with any explicit showing within FEHBA or its legislative history (except for a tortured interpretation of FEHBA's preemption provision) that Congress intended federal courts to adjudicate reimbursement claims.

Blue Cross supports its argument for federal subject matter jurisdiction with only general assertions that uniformity is needed in applying plan terms and that the federal treasury is affected. Blue Cross ignores, however, that the reimbursement terms it relies on are contained in the Statement of Benefits, a document Blue Cross prepared and issued to insureds, and not

in the contract between it and OPM. The Blue Cross/OPM contract only addresses subrogation rights, not reimbursement, and, notwithstanding, both concepts are outside Congress's explicit jurisdictional scope for FEHBA. And with respect to reimbursement matters, Blue Cross, not OPM, authors the terms and directs how to proceed.[3]

Allowing federal jurisdiction here would unnecessarily burden federal employees and the courts with duplicitous litigation, requiring state and federal courts to resolve different parts of the same case. State courts are well-qualified to handle contract issues and, given that the funds Blue Cross seeks to lien against are obtained in state court, the reimbursement question should be resolved there as well.

Petitioner and the Government offer no controlling authority that even resembles the record and issue we have here, where

3. Set forth in Cruz's pending certiorari petition is the Department of Justice's concession that Blue Cross has sole authority over reimbursement decisions:

> Medicare is a health insurance program maintained and underwritten by the Federal Government itself, in which carriers and fiscal intermediaries act as agents of the Government and perform functions that would otherwise be performed by the Government. In contrast, FEHBA carriers do not perform outsourced governmental tasks, are not agents of the Government, and do not act on behalf of OPM. Rather, they function as independent economic entities that offer and run their own health insurance plans, performing a role that is not governmental in nature but, instead, is akin to their activities as insurers in the private-sector marketplace. An extension of the principle in the cases cited by BCBS beyond the Medicare context to the FEHBA context would be unwarranted and would distort OPM's relationship with BCBS.

Cruz, No. 04-1657 (petition pending), at 6 (Excerpt from "Statement of Interest of the United States of America" at 19-20, filed July 30, 2004, in *Doyle, Cruz et al. v. Blue Cross Blue Shield of Illinois*, No. 00 CH 14182 (Cir. Ct. of Cook County, Illinois, Chancery Div.) (Judge Peter Flynn, presiding)).

the Court found subject matter jurisdiction exists. Finding jurisdiction on the issue raised here would significantly loosen the federal question jurisdictional standards and call into question this Court's jurisprudence.

ARGUMENT

Absent diversity jurisdiction, a federal court's power to hear cases is limited to those "arising under" the Constitution, Federal law, or treaties. U.S. Const. Art. III, § 2; 28 U.S.C. § 1331. The term "arising under" has been clarified in the development of the "well-pleaded complaint rule," which limits the types of cases that arise under the federal Constitution and laws of the United States. *Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal. et al.*, 463 U.S. 1, 9-10 (1983). This rule provides that "federal jurisdiction exists only when a federal question is presented on the face of the plaintiff's properly pleaded complaint." *Caterpillar, Inc. v. Williams*, 482 U.S. 386 (1987).

In order to avoid being strictly bound by the language of the complaint, courts have relied on the "artful pleading doctrine" to look beyond a plaintiff's characterization of a claim to determine whether the claim truly arises under federal law. This doctrine is applicable where, as here, the plaintiff purports to assert a federal claim where none exists. *Merrell Dow Pharmaceuticals Inc. v. Thompson*, 478 U.S. 804, 807-8 (1986) (remanding case to state court for lack of federal question jurisdiction even though complaint asserted allegations under federal law); *Gully v. First Nat. Bank in Meridian*, 299 U.S. 109, 114 (1936) ("A suit to enforce a right which takes its origin in the laws of the United States is not necessarily, or for that reason alone, one arising under those laws, for a suit does not so arise unless it really and substantially involves a dispute or controversy respecting the validity, construction, or effect of such a law, upon the determination of which the result depends.").

Petitioner argues that federal question jurisdiction exists over its reimbursement claim under FEHBA, the contracts and regulations established pursuant to FEHBA, and federal common law. Pet. Br. 14. For the reasons set forth herein, Blue Cross's "artfully pled" complaint fails to (and indeed cannot) plead a valid federal claim and, thus, federal question jurisdiction does not exist.

I. CONGRESS DID NOT INTEND REIMBURSEMENT CLAIMS BETWEEN PRIVATE PARTIES TO BE LITIGATED IN FEDERAL COURT

A plain reading of the entire FEHBA statute and its legislative history, coupled with the statute's purpose to protect federal employees against increased costs, strongly suggests that Congress did not intend for state court litigants to be forced into federal court to resolve reimbursement claims.

A. FEHBA's Jurisdictional Provision, Granting Federal Court Jurisdiction To Claims Against the United States, Should Not Be Judicially Expanded

Where a federal statute expresses the parameters of district court jurisdiction, that expression is "strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly." *Great-West Life v. Knudson*, 534 U.S. 204, 209 (2002) (emphasis in original) (*citing*, *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993)).

A plain reading of FEHBA's jurisdictional provision clearly shows that FEHBA does not create a private right of action for a health insurer to sue its members in federal court. That provision states that district courts have jurisdiction over "a civil action or claim *against the United States* founded on this chapter." 5 U.S.C. §8912. (Emphasis supplied).

Petitioner and the Government argue that FEHBA's jurisdictional provision does not bar the kind of claims Petitioner brought or the parties that Petitioner sued in this case. (Pet. Br. 29-30 fn2; Govt. Br. 27fn5). However, had Congress intended

federal courts to have jurisdiction over all civil actions arising under FEHBA, it could have easily provided for exclusive jurisdiction of all claims arising under that legislation (as it did when enacting, among others, ERISA legislation), rather than limiting jurisdiction solely to claims against the United States. *See, Bread Political Action Committee, et al. v. Federal Election Commission*, 455 U.S. 577, 580 (1982) ("Jurisdictional statutes are to be construed with precision and with fidelity to the terms by which Congress has expressed its wishes'"). Expanding jurisdiction to include disputes between parties violates this Court's instruction to not expand federal court powers "by judicial decree". *Kokkonen v.Guardian Life Ins. Co. of America*, 511 U.S. 375, 377 (1994); *Finley v. United States*, 490 U.S. 545, 547 (1989) ("courts which are created by law, and whose jurisdiction is defined by written law, cannot transcend that jurisdiction.").

Petitioner's and the Government's expansive interpretation of FEHBA conflicts with an analogous situation addressed by this Court in *Finley*. In *Finley*, a widow sought to amend her federal action against the United States, brought under the Federal Tort Claims Act ("FTCA"), to add state law claims against non-federal parties. 490 U.S. at 546-47. In declining jurisdiction over non-federal parties, this Court held that the text of the FTCA, which provides that "the district courts . . . shall have exclusive jurisdiction of civil actions on claims against the United States", 28 U.S.C. §1346(b), "means against the United States and no one else." *Id.* at 552.

The text of the FTCA's and FEHBA's jurisdictional provisions are substantially the same, *cf.*, 28 U.S.C. 1346(b), *with* 5 U.S.C. 8912, and, thus, should be similarly applied. *See, Bragdon v. Abbott*, 524 U.S. 624, 645 (1998) (when "judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its . . . judicial interpretations as well."). To allow Blue Cross to sue a plan member in federal court under FEHBA would

require an extremely liberal interpretation of FEHBA's jurisdictional provision which Congress clearly did not intend. *See*, *Finley*, 490 U.S. at 552 (indicating that if Congress wanted to, it could have easily worded the statute to broaden its reach beyond only actions against the United States).

Moreover, limiting federal jurisdiction to claims against the United States comports with other FEHBA provisions, its legislative history, and OPM's regulations. Indeed, actions against the United States encompass enrollee claims against OPM for coverage and benefit denials, and benefit cost disputes. These sort of claims are addressed in FEHBA's preemption provision, 5 U.S.C. §8902(m)(1) (allowing "provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits . . . [to] preempt any State or local law . . . which relates to health insurance or plans"), and the meaning of the coverage and benefit terms can be gleaned throughout the FEHBA statute and its legislative history. Those sources show that Congress's interest in this area was limited to medical care issues, such as the type of procedures covered and the cost of those benefits. Furthermore, the FEHBA regulation requiring that "denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors, 5 C.F.R. §890.107, further supports the federal jurisdiction limitation argued by Respondent, to only suits by beneficiaries against OPM. *See*, *McVeigh*, 396 F.3d at 145 fn7 (holding that the OPM's lack of regulations "to open the federal courts to insurance carriers seeking reimbursement from beneficiaries" signifies what Congress did not intend).[4]

4. Numerous courts agree with the Second Circuit's literal, narrow interpretation of FEHBA's jurisdictional provision. *See*, *McVeigh*, 396 F.3d 136, 145 (2d Cir. 2005) ("§8912 does demonstrate that Congress considered jurisdictional issues in enacting FEHBA and did not hesitate expressly to confer federal jurisdiction where it found it necessary to do so."); *Botsford v. Blue Cross & Blue Shield of Mont.*, 314 F.3d 390, 398-99 (9th Cir. 2002) ("FEHBA provides federal courts with jurisdiction solely over suits against the United States", further stating: "we conclude

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In contrast, expanding federal jurisdiction beyond claims against the United States would violate Congressional intent and "overload[] the [federal] courts" with matters that are and can be easily addressed by state courts. *See, United States v. Erika*, 456 U.S. 201, 209-10 (1982) (strictly construing medicare statute and its legislative history which precluded federal question jurisdiction over Medicare part B claims). Without any, let alone clear, Congressional intent that insurer reimbursement claims were meant to be resolved in federal court, this Court must refrain from judicially expanding FEHBA's jurisdictional provision. *Id.*; *see also, United States v. Sherwood*, 312 U.S. 584 (1941) (holding that suits under the Tucker Act, 28 U.S.C. 1346(a)(2), can only be brought in federal court and only against the United States); *City of Kenosha, Wisconsin et al. v. Bruno*, 412 U.S. 507, 513 (1973) (holding no federal jurisdiction existed over civil rights action against municipalities because the Court found that "the legislative history" and "the language actually used by Congress" did not "bring municipal corporations within the ambit of s1983.").[5]

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that Congress intended to limit suits over benefits under a FEHBA plan to only one defendant: United States."); *Goepel v. Ntl. Postal Mail Handlers Union*, 36 F.3d 306, 307 (3d Cir. 1994) (remanding insured's suit against insurer because, among other reasons, "the United States is not a party to this action."); *Howard v. Group Hospital Svc.*, 739 F.2d 1508, 1511 (10th Cir. 1984) (holding that district court lacked federal jurisdiction on claims brought by FEHBA plan insured against insurer because "the United States here acts as the agent, not the insurer of health benefits."); *Ramirez v. Humana, Inc.*, 119 F. Supp. 2d 1307, 1312 (M.D. Fla. 2000) (acknowledging jurisdiction under FEHBA is limited to suits against the United States); *Mooney v. Blue Cross of Western Penn.*, 678 F. Supp. 565, 566 (W.D. Pa. 1988) ("[i]f Congress had intended . . . district courts to have jurisdiction over private actions by [FEHBA] plan participants against plan providers, we believe it would have explicitly stated so.").

5. The Petitioner's reliance on *Verizon Maryland, Inc. v. Public Service Commission of Maryland*, 535 U.S. 635 (2002), is misplaced.
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B. Congress Did Not Intend FEHBA's Preemption Provision To Cover Insurer Reimbursement Claims Against Enrollees.

Petitioner and the Government ignore FEHBA's express preemption limitations in arguing that this provision supports federal jurisdiction over Blue Cross's reimbursement claim. FEHBA's preemption provision states, in relevant part:

> The terms of any [FEHBA] contract . . . which relate to the nature, provision or extent of coverage or benefits (including payments with respect to benefits) shall supercede and preempt any State or local law . . . which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

Petitioner and the Government make several errors in contending that FEHBA's preemption provision covers this dispute. First, Blue Cross filed suit against McVeigh in federal court based upon reimbursement language contained in the Statement of Benefits that Blue Cross prepared and issued to FEHBA plan enrollees. That reimbursement provision was not mandated by OPM, which merely authorizes the distribution of that document. *See*, *Cruz* petition (pending) at 6 (identifying the Government's concession that Blue Cross operates independently); *Doe v. Devine*, 703 F.2d 1319, 1333 fn62 (D.C. Cir. 1983) (J. Ginsburg) ("OPM can negotiate, but cannot 'impose', contract terms."). No express terms of the OPM/Blue Cross contract, a separate document from the Statement of

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(Pet. Br. 29-30 fn2). That decision did not address a jurisdictional provision or language even close to that contained in FEHBA. *Verizon* addressed the Telecommunications Act of 1996, 47 U.S.C. 251, *et seq.*,and, specifically, 47 U.S.C. 252(e)(6), which set forth "procedures for negotiation, arbitration, and approval of agreements". The Court unsurprisingly found that the provision's language did not "eliminate jurisdiction under §1331". *Id.* at 643.

Benefits, is at issue in this case. *See*, *Lingle v. Magic Chef, Inc.*, 486 U.S. 399, 407 (1988) (declining to preempt state tort law under LMRA, where claim did not require interpretation of collective bargaining agreement).

Next, the reimbursement language on which Petitioner and the Government rely does not "relate[] to" "coverage or benefits (including payments with respect to benefits)". The Government distorts the plain meaning of "coverage or benefits" under FEHBA in defining a carrier's reimbursement lien as part of the "net benefits" an enrollee receives from the carrier. (Govt. Br. 19). This strained interpretation is made without any reference to the description of benefits set forth in FEHBA and its legislative history. This position stretches FEHBA's "relate to" clause further than Congress intended and distorts the meaning of "benefits" under FEHBA, and is based upon a tenuous, indirect connection between money paid by the plan (which were funded in large part by premiums paid by insureds) and a recovery received by Respondent from a third-party tortfeasor. Petitioner's and the Government's rationale – that a plan's reimbursement reduces the "benefit" provided to the insured – ignores the fact that carrier coverage and benefit determinations, and payments with respect to those, are completed long before reimbursements are asserted and recovered.

A plain reading of the FEHBA statute and its legislative history shows no direct connection exists linking "coverage or benefits" with Congressional intent to apply preemption here, and that no material link or relation should be implied.

1. *FEHBA's Statutory Scheme Shows That "Benefits", As Described Under FEHBA, Do Not Include Reimbursements Against Third-Party Recoveries*

Section 8903 of FEHBA identifies four types of health benefit plans that OPM may contract for or approve. 5 U.S.C. §8903. Plaintiff was a member of the Service Benefit Plan, which is described in subsection 8903(1). That subsection, like the other three, refer to FEHBA section 8904 to describe the "benefits" covered under each plan. Section 8904, titled "Types of benefits", states, in relevant part:

> (a) The benefits to be provided under plans described by section 8903 of this title may be of the following types:
>
> (1) Service Benefit Plan. —
>
> (A) Hospital benefits.
>
> (B) Surgical benefits.
>
> (C) In-hospital medical benefits.
>
> (D) Ambulatory patient benefits.
>
> (E) Supplemental benefits.
>
> (F) Obstetrical benefits.

It is clear that this FEHBA section, which provides guidance on Congress's intent regarding the scope of the word "benefits", does not encompass a private carrier's reimbursement claim against an insured.

2. *FEHBA's Legislative History Further Shows That Congress Did Not Intend To Preempt Areas Involving Reimbursement*

In 1977, eighteen years after its enactment, Congress amended FEHBA to add a preemption provision, § 8902(m)(1). This provision was intended, designed and drafted to be a very narrow, surgical response to a specific conflict which bothered federal officials. The problem involved some states attempting to require federal government health insurance plans to include certain types of coverage (specifically, treatment by chiropractors) which the federal plans did not then include. Thus, 5 U.S.C. § 8902(m)(1) was created to preempt state laws only to the extent that state laws attempted to force federal health plans to include benefits other than those chosen by the federal plan. *See, e.g.*, House Report No. 95-282 (1977), pp. 4-5:

> Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal employee's health benefits plans.
>
> * * *
>
> For example, the Indemnity Benefit Plan (Aetna) pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State law requires coverage for such services.
>
> * * *
>
> The effect of this amendment is to preempt application of State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage . . .

Petitioner's contention that Congress intended to preempt all state laws related to FEHBA plan contract terms is belied by statements made by the agency overseeing this statute. In a letter to Congress from the United States Civil Service Commission ("USCSC"), the predecessor of OPM, which was attached to House Report No. 95-282, the USCSC acknowledged the narrow scope of FEHBA's preemption:

> It is a form of limited preemption.
>
> * * *
>
> more and more States have legislated the kinds of benefits and medical practitioners that carriers doing business in these States must cover. These laws in effect presented serious problems from the standpoint of the uniformity of benefits under the program. It also placed carriers in serious jeopardy of loss of their license in a State unless they were to approve pay for a benefit not provided under our contract but required by State law.

Id. at 6.

In 1998, Congress amended FEHBA's preemption provision to broaden its reach over benefits and coverage issues by merely deleting the phrase "to the extent that such law or regulation is inconsistent with the provisions of the Federal employees' health benefits contract". 5 U.S.C. §8902(m)(1) (1997). Significantly, Congress, in amending the provision, did not delete the limiting phrase "coverage or benefits". The legislative history of this amendment, which was part of the passage of the Federal Employees Health Care Protection Act of 1997, further shows that the amended preemption provision still solely focused on preventing State laws addressing benefits and coverage issues that were surviving under the old provision.

> These changes would affect states that have requirements governing what types of organization can provide health care when those requirements are

> different from those under federal contracts. This preemption would be considered a mandate under UMRA. However, because the only effect of the preemption would be to limit the application of state law in some circumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

S. Rep. No. 105-257, pt. V (1998).

Congress expressed its limited expansion of the statute to capture other pure benefit and coverage issues in its description of the amendment as "technical changes", *Id.* at pt. I, and in its statement that costs to state or local governments "would be minimal". *See also*, H.R. Rep. No. 105-374, pt. 2, at p. 8 (1998) ("For example, a carriers effort to establish a preferred provider organization (PPO) across the country would not be jeopardized by State-mandated 'any willing provider' statutes."). Nothing in the legislative history of FEHBA's preemption provision suggests that Congress was concerned with allowing state courts to adjudicate carrier reimbursement claims asserted against third-party tort recoveries. *See*, *McVeigh*, 396 F.3d at 149 (finding no indication from the statute's words or its legislative history "that Congress meant to channel into federal courts the business of resolving, pursuant to judicially fashioned federal common law, the range of contract claims relating to" a plan's reimbursement lien) (*citing*, *American Airlines, Inc. v. Wolens*, 513 U.S. 219, 232 (1995) (rejecting carrier's argument that Airline Deregulation Act barred state breach of contract claim)).[6]

6. Although it did not reach the issue, the Second Circuit's concern over the constitutionality of FEHBA's preemption provision is valid. *McVeigh*, 396 F.3d at 143 (questioning whether "contract terms" written by Blue Cross can "preempt state law because, as it believed, 'only federal law may preempt state and local law"). The Second Circuit reasoned that the "FEHBA-authorized contracts . . . are not" federal laws because "the government does not impose contract terms as it would impose a law. [r]ather, the OPM negotiates the contract terms

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This review of the text and legislative history of FEHBA's preemption provision shows that Petitioner's and the Government's position violates this Court's standard for

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privately with insurance providers . . . who are under no obligation to enter into the contracts in the first place." *Id.* at 144 (distinguishing contracts and tariffs by recognizing that a "tariff, required by law to be filed, is not a mere contract, [i]t is the law"; *citing, Evanns v. AT&T Corp.*, 229 F.3d 837, 840 fn 9 (9th Cir. 2000)). In refusing to reach the constitutional issue, the court narrowly construed the provision making it clear that its construction required that the federal law preempting state law may be federal common law or the FEHBA statute provisions themselves, but it must be law – not contract terms. *Id.* at 145.

This Court is certainly able to address the constitutional issue if it deems necessary, especially since the Government raised it in their brief (Govt. Br. 22-23). *See, New York City Transit Authority v. Beazer*, 440 U.S. 568, 583 fn24 (1979) ("The failure of the Court of Appeals to address the statutory issue decided by the District Court does not, of course, prevent this Court from reaching the issue."). Moreover, this Court's precedent support's the Second Circuit's concern. *See, Wolens*, 513 U.S. at 229 fn5 ("the word series 'law, rule, regulation, standard, or other provision,' . . . connotes official, government-imposed policies, not the terms of a private contract."); *Id.* at 241 (J. O'Connor, *concurring in the judgment in part and dissenting in part*) ("To be sure, the terms of private contracts are not 'laws,' any more than the guidelines at issue in *Morales* were 'laws.'"); *Clinton v. City of New York*, 524 U.S. 417, 448-49 (1998) (holding "Line Item Veto Act" unconstitutional, stating: "Something that might be known as 'Public Law 105-33 as modified by the President' may or may not be desirable, but it is surely not a document that may 'become a law' pursuant to the procedures designed by the Framers of Article I, §7, of the Constitution"); *United States v. New Mexico*, 455 U.S. 720, 737 (1982) (rejecting immunity shield for government contractor despite them having "modified their agreements two years into the litigation in an obvious attempt to strengthen the case for nonliability", further stating: "We cannot believe that an immunity of constitutional stature rests on such technical considerations, for that approach allows any government functionary to draw the constitutional line by changing a few words in a contract.") (*internal quotes and citation omitted*).

applying preemption statutes. *See, CSX Transportation v. Easterwood*, 507 U.S. 658, 664 (1993) (holding that courts should only preempt when it is the "clear and manifest purpose of Congress" to do so). Long before the preemption provision was added to FEHBA, state courts were well-versed in adjudicating subrogation and reimbursement claims. *See, Pan American Petroleum Corp. v. Superior Ct. of Delaware*, 366 U.S. 656, 663 (1961) (finding that claims for restitution are "traditional common-law [state] claims" that "do not lose their character because . . . of federal regulation"). Blue Cross and the Government do not offer any support for their argument that Congress intended to wrest away this traditional state court function.

Moreover, Petitioner and the Government fail to identify any specific state law "which relates to health insurance or plans" that conflicts with Blue Cross's right to reimbursement. New York does not have an anti-subrogation or anti-reimbursement law. Any law that Petitioner attempts to raise in reply or at oral argument would at best be a law of general application not specifically targeted to health insurance or plans. *See, Mackey et al. v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 846 (1988) (refusing to preempt "run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan . . . [even though these suits] obviously affect[] and involv[e] ERISA plans and their trustees"); *McVeigh*, 396 F.3d at 146 fn10 (finding no state law conflict existed, further stating: "[i]f Congress had not wished to limit the types of state laws subject to preemption, it could have quite easily provided that 'federal law shall govern the interpretation and enforcement of contract terms'"). Thus, even if Congress intended FEHBA to preempt the reimbursement field, there still is no showing that Congress intended to preclude state courts from addressing those issues.

Finally, the Petitioner's and the Government's comparison to ERISA's preemption provision and this Court's interpretation of that provision is misplaced. FEHBA's provision, unlike

ERISA's, states that only plan terms that relate to "coverage or benefits" preempts state law. *Cf.* 5 U.S.C. 8912(m)(1) *with* 29 U.S.C. 1144(a). No such limitation is contained in ERISA and no coverage or benefit dispute is at issue in this case. *See*, *FMC Corp. v. Holliday*, 498 U.S. 52, 62, 64 (1990) (instructing courts to give life to "distinction[s]" in statutes where Congress is aware of those differences and "has chosen not to alter", further instructing courts to find meaning in the words Congress uses in "preemption clause[s]"). Moreover, as the Second Circuit found in declining to extend ERISA precedent, ERISA is "significantly more comprehensive than FEHBA, in that it contains multiple preemption provisions and a detailed civil enforcement scheme intended to completely supplant state law." *McVeigh*, 396 F.3d at 147-48 & fn13 ("reject[ing] . . . suggestion that we should rely on ERISA-related precedent to determine the preemptive reach of FEHBA" and recognizing FEHBA's limiting term not found in ERISA's preemption provisions, "which requires that the preempting contract term 'relate to . . . [health] coverage or benefits'"). Furthermore, this Court has already construed ERISA narrowly with respect to a plan's asserted reimbursement claim, as here, and held that such a claim does not arise under federal law. *See*, *Great West*, 534 U.S. at 221 fn5 (construing the phrase "appropriate equitable relief" to exclude a Plan's reimbursement claim and rejecting plan's argument that jurisdiction is warranted because it "is consistent with ERISA's purposes").[7] Petitioner offers no support for

7. The Government's reliance on *FMC Corp.*, is misplaced. In *FMC*, this Court addressed whether ERISA's broader preemption provision applied to prempt "Pennsylvania's anti-subrogaton law", which "[did] not merely have an impact on the insurance industry, it [was] aimed at it." 498 U.S. at 61. That state law prohibited benefit "plans from being structured in a manner requiring reimbursement in the event of recovery from a third-party." *Id.* Unlike in *FMC*, here the Government fails to point to *any* state law that prevents Blue Cross from asserting its reimbursement claim against Respondent, let alone any state law that is targeted at this plan's reimbursement provision.

extending FEHBA's much narrower preemption provision further than ERISA's reach.[8]

C. Federal Common Law Should Not Be Created To Resolve A Contract Dispute Between Private Parties

Judicial creation of federal common law is limited to those "narrow areas . . . concerned with the rights and obligations of the United States, interstate and international disputes implicating the conflicting rights of States or our relations with foreign nations, and admiralty cases." *Texas Indus., Inc. v. Radcliff Materials, Inc.*, 451 U.S. 630, 641 (1981). The standards for creating such laws were set forth by this Court in *Boyle v. United Tech. Corp.*, 487 U.S. 500 (1987). Neither prong of *Boyle's* two-part test are met, however, to support creation of federal common law here. Blue Cross's reimbursement claim simply does not implicate a "uniquely federal interest", nor does it involve a "significant conflict" between an identifiable "federal policy or interest and the operation of state law". *Id.* at 504-07.

1. *No "Unique Federal Interest" Exists*

Petitioner's and the Government's contentions that the impact of reimbursement on the federal treasury creates a substantial, unique federal interest and that the federal policy of uniform health benefits for FEHBA plan enrollees is in conflict with state law (Pet. Br. 22; Govt. Br. 7, 25) are unsupported and erroneous. The United States General Accounting Office's ("GAO") December 2002 report, analyzing premium growth in FEHBA plans, undercuts Petitioner's position. In that report, the GAO indicates that most of the increases in FEHBA plan premiums were a result of higher

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8. Amicus are aware that this Court is presently addressing whether the *Great West* decision left the federal door open to an ERISA plan asserting a limited type of reimbursement claim. *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S. Ct. 735 (Nov. 28, 2005) (*cert. granted*). Given the material differences in the language of the ERISA and FEHBA statutes, the outcome of that decision, even if the Plan prevails there, will not be dispositive here.

prescription drugs and hospital care expenses. GAO's December 2002 FEHBA Premium Growth Report, at 2, *www.gao.gov/new.items/d03236.pdf*, (visited March 30, 2006). Nowhere in the thirty-one page report and appendixes does it suggest that carrier reimbursements have had or will have a material affect on premiums. Indeed, reimbursements from third-party recoveries is not even mentioned in the report.

Moreover, Petitioner and the Government ignore the inherent nature of Blue Cross's claim. Petitioner's reimbursement claim does not involve any further "payments with respect to benefits" (as FEHBA's preemption provision addresses), but rather seeks reimbursement from a third-party recovery that Respondent, not Petitioner, pursued and obtained in a state court action.

Contrary to Petitioner's and the Government's suggestion, litigating reimbursement claims in federal court may have the opposite, adverse affect on the Federal Treasury. If injured insureds are required to litigate in two, rather than one legal forum (initiating the tort action in state court only to be later dragged into federal court to resolve the carrier's reimbursement claim), the costs of litigation would increase and would likely result in some litigants deciding against pursuing a third-party case. This chilling effect on certain tort actions will reduce Blue Cross's reimbursement recoveries and/or increase its costs in pursuing subrogation claims.[9] It would also result in flooding

9. It is undisputed that this case raises a reimbursement claim, not a subrogation claim. The distinction between subrogation and reimbursement should be noted if any importance is given to the subrogation provisions contained in OPM's contract with Blue Cross. That contract is silent on reimbursement, which is only contained in the Statement of Benefits authored and issued by Blue Cross.

Several important distinctions exist between the two concepts. Subrogation allows Blue Cross to step into the shoes of the injured party and assert its recovery rights directly against the tortfeasor. In a subrogation setting Blue Cross initiates the action and advances the effort and expense to secure a recovery. *See*, Leishman, Adding Insult

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the federal courts and thereby increasing federal court expense with matters that can and should be adjudicated by state courts. *See, Erika, Inc.*, 456 U.S. at 209-10 (cautioning against unnecessarily burdening the federal court system); *see also, Nevada v. Hicks*, 533 U.S. 353, 366 (2001) ("It is certainly true that state courts of 'general jurisdiction' can adjudicate cases invoking federal statutes, such as §1983, absent congressional specification to the contrary. 'Under [our] system of dual sovereignty, we have consistently held that state courts have inherent authority, and are thus presumptively competent, to adjudicate claims arising under the laws of the United States'" (*citing, Taflin v. Levitt*, 493 U.S. 455, 458 (1990)).[10] Here,

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to Injury: ERISA, Knudson, and the Error of the Possession Theory, 89 Minn. L. Rev. 1214, 1215-16 (2005). In contrast, with reimbursements, Blue Cross does nothing to secure the third-party recovery, which is pursued solely by the injured insured in state court (or by way of negotiated settlement). *Id.* Instead, Blue Cross asserts a contractual right to repayment from the insured's third-party recovery. *Id.* Thus, even if a plausible rationale exists, pursuant to the OPM/Blue Cross contract, to allow these subrogation matters to be heard in federal court, that same reasoning would not apply to reimbursement situations.

10. The Government's position in this case is curious since it is undercut by the contrary position it took in *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), where the court addressed an insured's tort and breach of contract action arising from an insurer's failure to pay claims under a FEHBA plan. There the Tenth Circuit concluded that the insureds claims "would have no direct effect upon the United States or its Treasury" because "[t]he Solicitor General, waiving his right to respond in these cases, advised us:

> In the course of the proceedings below, the United States determined that its interests would not be directly affected by the resolution of these issue[s] and therefore did not participate in briefing or argument in the court of appeals. In view of these considerations, the United States does not intend to respond to the petitions unless it is requested to do so by the Court.

Id. at 1510.

nothing in FEHBA suggests that Congress intended to bar state courts from hearing these matters, even if a federal interest is involved.

The Government's suggestion that the federal courts would not be burdened with factual disputes with respect to reimbursement matters (Govt. Br. 30) is belied by ample evidence to the contrary. According to a 1993 article in the New York Times, the "General Accounting Office has estimated that 99 percent of hospital bills contain overcharges". Elisabeth Rosenthal, *Confusion and Error Are Rife In Hospital Billing Practices*, N.Y. Times, January 27, 1993. A recent Chicago Tribune article confirmed similar results. Lorene Yue, "*Examine hospital bills for mistakes that can ail you*", Chicago Trib. Online Ed., February 20, 2005 ("Medical claims advocates estimate that 8 of 10 bills contain some kind of mistake, ranging from data-entry errors and duplicate charges to failure to provide group discounts for related services"). Resolving these and other factual disputes should be given to the state courts who would already be intimately familiar with the underlying case and Blue Cross's claim.

Additionally, Petitioner's and the Government's "vague assertions about the need for uniformity" and "generalized pleas for uniformity" are insufficient to support a federal interest. *See*, *Woodward Gov Co., v. Curtiss-Wright Flight Sys., Inc.*, 164 F.3d 123, 129 (2d Cir. 1999) (*citing*, *U.S. v. Kimbell Foods, Inc.*, 440 U.S. 715, 730 (1979)). Petitioner's claim against McVeigh is based upon the alleged breach of the terms of the Statement of Benefits, a document written and issued by Blue Cross, and does not involve any terms contained in the OPM/Blue Cross contract. Unlike in *Boyle*, neither the OPM or the Government mandates the language contained in the Statement of Benefits issued by Blue Cross to insureds. *See*, *Boyle*, 487 U.S. at 507 (finding that a uniquely federal interest is established where the "terms of Government contracts . . . specified by the Government" are affected); *cf. Devine*, 703 F.2d at 1333 fn62 ("OPM can negotiate, but cannot 'impose,' contract terms.");

see also, *Cruz*, No. 04-1657 (petition pending) at 6 (conceding that Blue Cross "function[s] as [an] independent economic entit[y]").

In *Miree v. DeKalb County, Georgia*, 433 U.S. 25 (1977), a plaintiff brought a third-party beneficiary claim pursuant to a contract between a County and the Federal Aviation Administration ("FAA") that was federally authorized by the Airport and Airway Development Act of 1970. The contract required the County to restrict the area around the airport to only those activities suitable for airport operations. *Id.* at 27. Plaintiff asserted that the County breached the contract by allowing a garbage dump adjacent to the airport which attracted birds and caused a plane crash. *Id.* Despite the contract being authorized by federal law and the Court acknowledging that "the operation of the United States in connection with FAA grants such as these are undoubtedly of considerable magnitude (similar to the arguments by Petitioner), the Court denied federal jurisdiction because it found no clear Congressional mandate to displace state law in these types of cases where private parties are involved. *Id.* at 32. Furthermore, as Blue Cross fails to establish here, the *Miree* Court also found "no direct effect upon the Federal Treasury". *Id.* at 29.[11]

This Court's decision in *Texas Indus.* is also applicable. There this Court addressed a party's suit brought under the federal antitrust laws, asserting a third-party action for

11. Petitioner's and the Government's reliance on *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943) is misplaced. There, unlike here, the United States was a party. The Government sued a bank seeking recovery on a check it issued that the bank paid on a forged indorsement. *Id.* at 365-66. The act of issuing the check, unlike the reimbursement claim raised here, directly arose from federal law. *Id.* at 365. In contrast, the reimbursement claim here arose only after Respondent achieved a tort recovery in state court and then only from Blue Cross's Statement of Benefits document. Also, in *Clearfield*, unlike here, there were "[v]arious treasury regulations govern[ing] the payment and endorsement of government checks". *Id.* at 367 fn2.

contribution against respondents if petitioner was found liable. The Court concluded that federal courts lacked jurisdiction to hear petitioner's contribution claim because, based on its review of the language of the Sherman and Clayton Acts, Congress did not address or otherwise imply that a right to contribution exists under those statutes. *Id.* 451 U.S. at 639-40. Despite the existence of a federal interest – in that a contribution claim would supplement federal enforcement and fulfill the objects of the statutory scheme – and despite Congress "expect[ing] the courts to give shape to the statute's broad mandate by drawing on common-law tradition", this Court held that creating federal common law was not appropriate because there was never a mention of the contribution issue during the statutes' "90 years" of existence, during which numerous amendments occurred. *Id.* at 642-45. The same reasoning equally applies here. FEHBA and its legislative history omit any mention of reimbursement issues, even after numerous amendments since the statute was enacted in 1959.

Finally, even if a federal interest exists here, "uniformity" would not be lost by allowing state courts to decide the reimbursement question. "[T]he route to review by this Court is open to parties aggrieved by adverse state-court decisions of federal questions." *Pan American Petroleum*, 366 U.S. at 665 (*citing*, *Great Northern Ry. Co. v. Merchants Elevator Co.*, 259 U.S. 285 (1922). "If the parties properly preserve their rights, a construction given by any court, whether it be federal or state, may ultimately be reviewed by this court either on writ of error or on writ of certiorari; and thereby uniformity in construction may be secured." *Id.*

2. *No Significant Actual State Law Conflict Exists*

"[W]hen courts decide to fashion rules of federal common law, the guiding principle is that a significant conflict between some federal policy or interest and the use of state law . . . must first be specifically shown." *Atherton v. F.D.I.C.*, 519 U.S. 213, 218 (1997). As explained herein, "[w]hat is fatal to [Blue

Cross's] position in the present case is that it has identified *no* significant conflict with an identifiable federal policy or interest." *O'Melveny & Myers v. F.D.I.C.*, 512 U.S. 79, 88 (1994).

II. PETITIONER'S AND THE GOVERNMENT'S ALTERNATIVE ARGUMENT FOR FEDERAL JURISDICTION IS UNAVAILING

Conscious of the difficulty to show that FEHBA provides federal question jurisdiction over the parties' dispute, Petitioner and the Government rely on a narrow body of caselaw allowing federal jurisdiction where, despite the absence of a federal cause of action, the claim turns substantially on questions of federal law. (Govt. Br. 25-29; Pet. Br. 41 fn5). As this Court has instructed, however, this doctrine applies only in narrow, limited situations. *See, Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, – U.S. –, 125 S. Ct. 2363 (June 13, 2005).

Petitioner and the Government heavily rely on this Court's *Grable* decision, which involved a former landowner suing in state court to quiet title against a tax sale purchaser, alleging that the Internal Revenue Service had given him inadequate notice of sale. *Id.* at 2366. Significantly, the *Grable* Court rejected previous loose interpretations of this doctrine that suggested an "expansive view that mere need to apply federal law in a state-law claim will suffice to open the 'arising under' door." *Id.* at 2367 (referring to interpretations under *Smith v. Kansas City Title & Trust Co.*, 255 U.S. 180 (1921), relied on by the Government here). The Court confirmed instead "that federal jurisdiction demands not only a contested federal issue, but a substantial one, indicating a serious federal interest in claiming the advantages thought to be inherent in a federal forum." *Id.* Further, even if established, the Court instructed that "the exercise of federal jurisdiction is subject to a possible veto. For the federal issue will ultimately qualify for a federal forum only if federal jurisdiction is consistent with congressional

judgment about the sound division of labor between state and federal courts governing the application of §1331." *Id.*

In *Grable*, unlike here, the plaintiff premised its superior title claim solely on interpretation of federal law, the federal tax statute. *Id.* at 2368 ("Whether Grable was given notice within the meaning of the federal statute is thus an essential element of its quiet title claim, and the meaning of the federal statute is actually in dispute"). Here, Petitioner and the Government do not rely on FEHBA, its legislative history or its contract. Rather, they solely rely on the Statement of Benefits that Blue Cross authored and issued to insureds. More importantly, Blue Cross does not, nor can it, argue that the reimbursement provision in that document needs interpretation or is in dispute. There simply is no existence of, or need to interpret, a substantial federal law in this case. This case is therefore weaker than the issue this Court held was outside of federal jurisdiction in *Merrell Dow*. *See*, *Grable*, 125 S.Ct. at 2369 (*citing*, *Merrell Dow*, 478 U.S. at 806 (rejecting federal jurisdiction even though "federal law would have to be applied to resolve the claim")).[12]

At bottom, *Grable* is a rule for hard cases, that allows the Court the flexibility to recognize federal jurisdiction in unusual situations which present a supervening need for federal jurisdiction over a state-created cause of action. The rarity with which those cases arise is evidenced by the fact that this Court has rarely exercised such power. The record in this case clearly does not fit within this extraordinary exception.

12. The lack of any Congressional indication of concern over reimbursement issues in FEHBA, and the burdensome effect it would have on federal courts to hear matters that state courts are cable of hearing, also strongly weigh against applying this doctrine. *See*, *Grable*, 125 S.Ct. at 2370-71.

CONCLUSION

Wherefore, amicus curiae, in support of Respondent, respectfully request that this Court affirm the judgment of the Court of Appeals.

Respectfully submitted,

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IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,
Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR PETITIONER

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QUESTION PRESENTED

Whether federal question jurisdiction exists over a suit by a federal government contractor to enforce, on behalf of the United States, a provision in a health benefits plan for federal employees that is part of a government contract established pursuant to the Federal Employees Health Benefits Act.

PARTIES TO THE PROCEEDING

All of the parties to the proceeding are identified in the case caption.

STATEMENT PURSUANT TO RULE 29.6

Empire HealthChoice Assurance, Inc., doing business as Empire Blue Cross and Blue Shield, is wholly owned by WellPoint, Inc., through WellPoint Holding Corp. and WellChoice Holdings of New York, Inc. WellPoint, Inc. is a publicly traded company, and no publicly held company owns ten percent or more of its stock. Empire HealthChoice Assurance, Inc., WellPoint Holding Corp., and WellChoice Holdings of New York, Inc. are not publicly traded.

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IN THE

Supreme Court of the United States

No. 05-200

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,

Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-45a) is reported at 396 F.3d 136. The opinion of the court of appeals denying Petitioner's petition for panel rehearing (Pet. App. 46a-51a) is reported at 402 F.3d 107. The order of the court of appeals denying Petitioner's petition for panel rehearing and for rehearing en banc (Pet. App. 52a-53a) is not reported. The

opinion of the district court (Pet. App. 54a-62a) is not reported but can be found at 2003 U.S. Dist. LEXIS 16276.

JURISDICTION

The judgment of the court of appeals was entered on January 14, 2005. Petitioner timely filed a petition for rehearing and for rehearing en banc. The court of appeals denied the petition for rehearing and for rehearing en banc on May 10, 2005. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914, provides in pertinent part:

5 U.S.C. § 8902(a):

The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

5 U.S.C. § 8902(d):

Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

5 U.S.C. § 8902(m)(1):

The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8903(1):

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service benefit plan. One Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

STATEMENT

In this action, a divided court of appeals held that the federal courts lack subject matter jurisdiction over a suit to enforce the terms of a health benefits plan governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. The suit was commenced by Empire HealthChoice Assurance, Inc. ("Empire"), which administers, in parts of New York, the largest plan in the FEHBA program: the Service Benefit Plan (the "Plan"). Local Blue Cross and Blue Shield entities, including Empire, administer the Plan in their particular localities pursuant to a federal government contract entered on their behalf by the Blue Cross and Blue Shield Association ("BCBSA") with the United States Office of Personnel Management ("OPM"). The Service Benefit Plan provides health benefits to over 4 million federal employees and annuitants and their dependents nationwide.

The particular Plan terms involved in this controversy concern the reimbursement of benefits. Reimbursement is a method of enforcing subrogation rights and arises when the

Plan has paid benefits to an enrollee for injuries and the enrollee then also collects from a third party in connection with those same injuries. In such circumstances, the Plan's provisions mandate that the enrollee must reimburse the Plan for the benefits it has paid.

Here, after Empire brought suit to enforce the reimbursement terms against the estate of an enrollee who refused to comply with those terms, the court of appeals rejected federal question jurisdiction; it found instead that state law applied to the controversy. It so ruled notwithstanding that the reimbursement terms Empire seeks to enforce are part of the OPM-BCBSA government contract; FEHBA sets forth a pervasively federal regulatory regime; FEHBA contains a broad preemption provision that displaces state law and is designed to ensure the application of nationally uniform legal rules; and the money collected through reimbursement inures to the benefit of the United States itself.

A. The Statutory, Regulatory, and Contractual Scheme

1. *The Service Benefit Plan.* Congress enacted FEHBA in 1959 to provide "a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees . . . , the costs of which [would] be shared by the Government, as employer, and its employees." H.R. Rep. No. 86-957, at 1 (1959), *reprinted in* 1959 U.S.C.C.A.N. 2913, 2914. Overall, Congress sought to "assure maximum health benefits for employees at the lowest possible costs to themselves and to the Government." *Id.* at 4, *reprinted in* 1959 U.S.C.C.A.N. at 2916.

To achieve these goals, FEHBA delegates expansive authority to OPM. Among its powers, OPM has the authority to contract with qualified carriers to offer a variety of health care plans, 5 U.S.C. § 8902, to distribute information on the available plans to eligible employees, *id.* § 8907, to promulgate

necessary regulations, *id.* § 8913(a), and to interpret the plans to determine the carrier's liability in an individual case. *Id.* § 8902(j).

Beginning in 1960, OPM's predecessor contracted with the BCBSA's predecessors to provide the Service Benefit Plan, a nationwide fee-for-service plan expressly described in FEHBA. *See* 5 U.S.C. § 8903(1). The contract has remained in force ever since, and currently OPM and BCBSA annually renegotiate it, including the premium rates and the scope of benefits to be provided under the Plan. In negotiating and signing annual amendments, BCBSA acts on behalf of the local Blue Cross and Blue Shield companies who administer the Plan in their respective localities.

2. *Plan Benefits Terms and Limitations*. By statute, each FEHBA contract, including the one for the Service Benefit Plan, "shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." 5 U.S.C. § 8902(d). The Statement of Benefits for the Service Benefit Plan is attached to and incorporated into the OPM-BCBSA contract and is the official description of benefits and other Plan terms. J.A. 89, 115, 158. Consistent with OPM's obligation to provide information about coverage, FEHBA mandates that a copy of the Statement of Benefits "shall be issued" to "[e]ach enrollee." 5 U.S.C. § 8907(b).[1]

---

[1] When citing to the OPM-BCBSA contract, we generally cite first to the 1996 version of the contract, since it governed at the time the Plan (from 1997 to 2001) paid the benefits for which it here seeks reimbursement. Amendments were then added annually to the 1996 contract, and in 2002 OPM and BCBSA signed a new version. We also include a citation to the relevant parts of the 2002 contract, in addition to the 1996 contract. When referring to the Statement of Benefits, we cite to the Statement of Benefits issued for 2001. On all of the terms relevant to this case, the various versions of the contract and Statements of Benefits are not materially different.

Of particular relevance to this case are the terms in the Service Benefit Plan's Statement of Benefits concerning reimbursement. The Statement of Benefits provides (J.A. 165):

> If another person or entity . . . causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:
>
> All recoveries you obtain (whether by lawsuit, settlement, or otherwise) . . . must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees . . . .

The OPM-BCBSA contract also elsewhere directly addresses the carrier's duties to collect reimbursement. It requires the carrier to make "a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention." J.A. 95, 125. Furthermore, the contract mandates that all Blue Cross and Blue Shield entities "shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract." *Id.*

3. *Plan Funding.* The Plan's funding is delineated both in FEHBA and in OPM's regulations. By statute, the government and the enrollee share responsibility for premiums payable to the Plan. 5 U.S.C. § 8906. The employing agency (or OPM for annuitants) pays 72% to 75% of the premium as part of its payroll costs that are funded by general appropriations. *Id.* § 8906(b)(1), (b)(2), (f). Premiums are deposited into a special Treasury fund called the Federal Employees Health Benefits Fund. *Id.* § 8909(a). A portion of each year's premiums are set aside for a "contingency reserve," which is also held in the Fund. *Id.* § 8909(b).

With respect to the Service Benefit Plan (and certain other FEHBA fee-for-service plans), the carrier draws against the

Fund on a "checks-presented" basis to pay for covered health care services. *Id.* § 8909(a); 48 C.F.R. § 1632.170(b). Any balance in the Fund is not the property of the carrier. Rather, the carrier's profit comes solely from a negotiated service charge, which is based on the carrier's performance. *See* 48 C.F.R. §§ 1615.404-4, .404-70; *see also Nat'l Ass'n of Postal Supervisors v. United States*, 21 Cl. Ct. 310, 315 (1990) ("The service charge is the only profit element of FEHBA. . . . [The] carrier may not make a profit on the premium charges themselves."), *aff'd mem.*, 944 F.2d 859 (Fed. Cir. 1991). If the Plan's costs in a given year fall below expectations, the resulting surplus is placed in the contingency reserve. 5 C.F.R. § 890.503(c)(3). The Plan's contingency reserve may be used, at OPM's discretion, to defray future rates, reduce future government and employee contributions, increase plan benefits, or refund the monies to the government and plan enrollees. 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2). Additionally, the carrier is entitled to use the contingency reserve in the event a given year's premium funds are insufficient to cover the Plan's costs. 5 C.F.R. § 890.503(c)(3)(i).

Under this fiscal regime, money collected under the Plan's reimbursement terms does not belong to the carrier. Pursuant to the OPM-BCBSA contract, the carrier must, and does, credit all reimbursement amounts to the Treasury Fund, the source for the benefits in the first place. *See* J.A. 92, 118-19 (OPM-BCBSA Contract § 2.5(b)); J.A. 50-51; *see also* 48 C.F.R. § 1652.216-71(b)(2)(i) (authorizing carrier to charge to contract all benefits costs "less any refunds, rebates, allowances or other credits received"); 1996 & 2002 OPM-BCBSA Contracts § 3.2(b)(2)(i) (2d Cir. App. A36-A37, A 303) (same).

4. *FEHBA's Preemption Provision*. FEHBA contains an express preemption provision, codified at 5 U.S.C. § 8902(m)(1). As amended in 1998, the preemption provision currently provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1) (2000) (codifying Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363 (1998)).

In enacting the current preemption language, which "broaden[ed]" an earlier version of the preemption clause, Congress sought to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997) (J.A. 24).

B. The Proceedings Below

Joseph McVeigh, a Plan enrollee living in New York, was injured in an accident in 1997. The Plan paid benefits of approximately $157,000 in connection with those injuries. Subsequently, Mr. McVeigh filed a state tort action against the third parties that allegedly caused his injuries, and his estate pursued that action after his death in 2001. His spouse and his child brought additional actions on their own behalf. In 2003, the parties to the state tort actions announced a settlement of $3,175,000.

When the estate refused to reimburse the Plan for the benefits paid to Mr. McVeigh, Empire brought suit in the United States District Court for the Southern District of New York. Seeking reimbursement of $157,000, Empire's complaint asserts claims for breach of the Plan terms and for declaratory relief. Empire invoked the district court's federal question jurisdiction, alleging that the "action is founded on [FEHBA]; on federal contracts and regulations established pursuant to FEHBA; and on federal common law." J.A. 41. The district court dismissed the case for lack of subject matter jurisdiction. Pet. App. 62a.

A divided court of appeals affirmed. Pet. App. 1a-45a. Judge Sotomayor wrote the majority opinion (*id.* at 2a-24a), with Judge Sack submitting a separate concurring opinion. *Id.* at 25a-26a. Judge Raggi dissented. *Id.* at 27a-45a.

The majority determined that federal question jurisdiction was absent because state law governed the controversy. The majority construed the "relates to" qualifier in the last phrase of FEHBA's express preemption provision as applying only to those state laws that *specifically* regulate health insurance or plans, excluding from FEHBA's preemptive scope state laws of general application, such as state contract law. Pet. App. 14a-19a. The majority recognized that, in interpreting similar language in the preemption provision in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a), this Court had reached an exactly opposite conclusion – namely, that state laws of general application are preempted. But the court of appeals viewed ERISA precedent as irrelevant to construing FEHBA's preemptive scope. Pet. App. 19a-21a.

The majority also found that federal jurisdiction could not be founded on federal common law, because it believed Empire could not satisfy the test enunciated in *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988). The majority reasoned that, under *Boyle*, Empire needed to establish an "actual, significant conflict with [federal] . . . interests," but could not do so. Pet. App. 6a-7a (internal quotation marks omitted).

Judge Raggi dissented, concluding that federal jurisdiction existed because "FEHBA contracts are enforceable through common-law breach of contract actions" (*id.* at 29a-30a) and those action cannot rest upon state law due to the preemption provision. She explained that, by providing for preemption, "Congress has identified a unique federal interest in ensuring national uniformity in the construction and enforcement of [FEHBA contract] terms." *Id.* at 35a. In addition, by amending the preemption provision in 1998 to eliminate language that conditioned preemption on an inconsistency between the con-

tract terms and state law, "Congress has implicitly authorized courts to employ federal common law to resolve disputes concerning coverage and benefits, even in the absence of the conflict generally required by *Boyle*." *Id.* Judge Raggi also rejected the majority's position that ERISA precedent should not be used to determine the reach of FEHBA's preemption provision, noting that the "statutes' preemption clauses are notably similar" and "the objectives of the two [preemption] laws are virtually identical" – to ensure uniformity. *Id.* at 39a.

The panel denied rehearing by a 2-1 vote, issuing a supplemental opinion that reaffirmed its previous rulings on the preemption provision and the *Boyle* test. Pet. App. 46a-51a. The supplemental opinion also rejected arguments made by the United States in a brief as amicus curiae supporting Empire's petition for rehearing. Specifically, the majority ruled that the preemption provision does not express any Congressional intent that FEHBA contract disputes should be heard in federal court. *Id.* at 50a.

SUMMARY OF ARGUMENT

The issue for decision is whether Empire's complaint raises a federal question. That issue arises against a backdrop of factors establishing the intensely federal character of Empire's suit: (1) Empire sues to enforce reimbursement terms contained in a contract expressly described in a federal statute, namely FEHBA; (2) the United States is a party to the contract; (3) a federal agency, OPM, had final authority for selecting the reimbursement terms that Empire here seeks to enforce; (4) any relief obtained in this reimbursement action would be credited to the U.S. Treasury, and Empire has no financial stake in the recovery; (5) the suit is brought by Empire essentially on behalf of the United States, under a requirement in the contract that Empire make a reasonable effort to collect reimbursement funds; and (6) Congress expanded the preemption provision in FEHBA in 1998 for the very purpose of clarifying that state law is displaced in favor of uniform federal rules. Given these

factors, the case falls squarely within two lines of this Court's precedent supporting federal jurisdiction.

I. Suits to enforce contracts that are contemplated by federal statutes may set forth federal claims that must be heard in federal court. *See, e.g., Jackson Transit Auth. v. Local Div. 1285, Amalgamated Transit Union*, AFL-CIO-CLC, 457 U.S. 15, 22 (1982). The determining factor is whether Congress intended that the contracts be "creations of federal law . . . and that the rights and duties in those contracts be federal in nature." *Id.* at 23 (internal quotation marks omitted).

Empire's claim meets this standard. Empire's suit seeks to enforce the reimbursement provision contained in the contract establishing the Service Benefit Plan, a contract that OPM enters under authority conferred in FEHBA. 5 U.S.C. § 8902(a). Both the contract and the Statement of Benefits provided to Plan enrollees, which is incorporated into the contract and contains the reimbursement requirement, are specifically described in FEHBA. 5 U.S.C. §§ 8903(1), 8902(d). Thus, the contract at issue here is expressly contemplated by federal statute.

In addition, every indication from the statute is that Congress intended the contracts establishing FEHBA plans and governing their administration to be creatures of federal law. The statute sets forth a detailed framework for regulating FEHBA plans from cradle to grave that is exclusively federal. It describes plan terms and funding mechanisms, and it appoints OPM as the sole authority for regulatory oversight. Congress left no role for state regulation.

Congress also included in FEHBA a broad preemption provision displacing any state law that "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The provision was first enacted in 1978 with the stated intent of establishing uniformity in benefits. It was then broadened in 1998 because Congress was concerned that courts were giving it an unduly narrow construction. The current provision closely parallels ERISA's

preemption clause, which this Court has interpreted expansively. Indeed, the legislative history of the 1998 amendment directly addresses the relevant question, describing "the intent of Congress . . . that FEHB contract terms . . . completely displace State or local law relating to health insurance or plans." H.R. Rep. No. 105-374, at 16 (1997) (J.A. 25). A specific goal of the provision was to facilitate "trying FEHB program claims disputes in Federal courts rather than State courts." *Id.* at 9 (J.A. 24). Hence, the preemption clause provides a specific statutory indication that Congress expected federal law to govern FEHBA contract matters.

Because FEHBA contemplates the contract establishing the Service Benefit Plan, and Congress in turn intended that the contractual obligations be treated as federal in nature, Empire's cause of action to enforce the contract is a federal claim. It can be assumed that Congress intended FEHBA contracts, "like ordinary contracts, to be enforceable by private suit upon a breach." *Jackson Transit*, 457 U.S. at 20-21. The statute as a whole and its preemption clause in particular, however, leave no room for the application of state law on which a contract claim for reimbursement could rest. Accordingly, the action to enforce contract terms must be grounded in federal law.

II. Even putting aside the *Jackson Transit* line of authority, federal jurisdiction exists under the general principles the Court has developed for applying federal common law to issues arising from federal programs. Under what is known as the "first holding" of *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943), and its progeny, disputes in which important federal interests are at stake are resolved in federal courts applying federal common law. Under that case's "second holding," state law is displaced as the federal rule of decision when the federal interests demand uniformity. These principles apply with particular force when the federal interest at stake is enforcement of the United States' own contractual rights. *See*,

e.g., *United States v. Little Lake Misere Land Co.*, 412 U.S. 580, 593-94 (1973).

This case, under *Clearfield Trust*'s first holding, must be resolved according to federal law. The dispute involves obligations arising under a contract to which the United States is a party. The dispute also arises under a nationwide federal program in which important interests of the United States are at stake. In this respect, reimbursement recoveries are credited to the U.S. Treasury and inure to the benefit of the United States, not the carrier. Because important governmental interests – contractual, programmatic, and financial – are present, *Clearfield Trust*'s first holding mandates here the application of federal common law. That essentially disposes of the jurisdictional issue, since a suit founded on federal common law, as much as a statute, raises a federal question.

Though the Court need not reach *Clearfield Trust*'s second holding, which invites a determination as to whether state law or a uniform federal rule should be adopted as the governing federal rule of decision, a uniform federal rule is required in this case. The preemption clause and other aspects of the FEHBA program establish Congress's desire for uniformity in resolving disputes involving FEHBA contracts. Consequently, under the second holding of *Clearfield Trust*, and under the slightly different analytical framework of *Boyle v. United Techs. Corp.*, 487 U.S. 500 (1988), state law must be displaced, and federal courts must apply a uniform body of federal law.

ARGUMENT

The overarching issue in dispute is whether the federal courts have federal question jurisdiction over this case. Federal question jurisdiction is governed by 28 U.S.C. § 1331, which states: "The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." A case plainly satisfies that statutory standard if federal law "'creates the cause of action.'" *Franchise Tax*

Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 9 (1983) (quoting *Am. Well Works Co. v. Layne & Bowler Co.*, 241 U.S. 257, 260 (1916)). Indeed, the "provision for federal-question jurisdiction is invoked by and large by plaintiffs pleading a cause of action created by federal law." *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 125 S. Ct. 2363, 2366 (2005).

Empire's complaint raises a federal cause of action. Empire sues to enforce the terms of a contract that is expressly set forth in a federal statute; the contract is also a government contract; Empire pursues the action on behalf of the United States, with any relief inuring to the United States' benefit; and the underlying federal program from which the contract derives is a pervasively federal scheme that Congress expected would be administered in a nationally uniform manner. Given all of these factors, Empire's claim is – under either of two theories – a federal claim and therefore "aris[es] under" federal law. 28 U.S.C. § 1331.

I. EMPIRE'S COMPLAINT RAISES A FEDERAL CLAIM BECAUSE IT SEEKS TO ENFORCE CONTRACTUAL OBLIGATIONS THAT ARE SET FORTH IN A FEDERAL STATUTE AND THAT CONGRESS INTENDED TO BE FEDERAL IN NATURE

A. An Action Raises a Federal Claim If It Seeks to Enforce Contractual Obligations That Are Contemplated by a Federal Statute and That Congress Intended to Be Federal in Nature

In a series of decisions, "the Court has determined that a plaintiff stated a federal claim when he sued to vindicate contractual rights set forth by federal statutes." *Jackson Transit Auth. v. Local Div. 1285, Amalgamated Transit Union, AFL-CIO-CLC*, 457 U.S. 15, 22 (1982). *Jackson Transit* involved a suit between private parties for breach of a collective bargaining agreement, where a federal statute had made entry into such

an agreement a condition to receipt of federal assistance under the statute. Surveying its rulings in the area, the Court said its "decisions demonstrate that suits to enforce contracts contemplated by federal statutes may set forth federal claims and that private parties in appropriate cases may sue in federal court to enforce contractual rights created by federal statutes." *Id.* at 22.

Jackson Transit ultimately found that, under the particulars of the statute at issue and its legislative history, Congress did not intend for actions alleging breach of the collective bargaining agreements to raise federal claims. Other decisions, however, have applied federal law to analogous contract enforcement actions brought by private parties. For instance, in *International Ass'n of Machinists, AFL-CIO v. Central Airlines, Inc.*, 372 U.S. 682 (1963), the Court held that a union had "a federally-created cause of action" to enforce an award of an airline adjustment board contained in a collective bargaining agreement entered pursuant to the Railway Labor Act. *Jackson Transit*, 457 U.S. at 22. That case, "for jurisdictional purposes, presented a substantial claim having its source in and arising under the Railway Labor Act." *Int'l Ass'n of Machinists*, 372 U.S. at 696. Likewise, in *Norfolk & W. R. Co. v. Nemitz*, 404 U.S. 37 (1971), the Court "decided that a railroad's employees stated federal claims when they alleged a breach of an agreement entered into by the railroad under § 5(2)(f) of the Interstate Commerce Act." *Jackson Transit*, 457 U.S. at 28 n.9; *see also Norfolk & W. R. Co.*, 404 U.S. at 45 (Blackmun, J., dissenting) (noting majority's holding "to the effect that federal district court jurisdiction exists here"). And in *American Surety Co. v. Shulz*, 237 U.S. 159 (1915), "the plaintiff's right of action . . . arose out of a Federal statute," because the plaintiff sued to enforce a bond "given by virtue of the laws of the United States" in order to pursue a federal appeal. *Id.* at 162, 160.

In each case, "the critical factor is the congressional intent behind the particular [statutory] provision[s]" from which the agreement springs. *Jackson Transit*, 457 U.S. at 22. "[I]f Congress intended that [the] . . . agreements . . . be 'creations of federal law,' . . . and that the rights and duties in those contracts be federal in nature, . . . then [the plaintiff's] suit states federal claims." *Id.* at 23 (quoting *Int'l Ass'n of Machinists*, 372 U.S. at 692). Another way of putting the inquiry is whether, in the statutory scheme, Congress "intend[ed] to create a body of federal law applicable" to the area. *Id.* at 27. A claim is federal in character where it falls in an area "'within which the policy of the law is so dominated by the sweep of federal statutes that legal relations which they affect must be deemed governed by federal law having its source in those statutes, rather than by local law.'" *Int'l Ass'n of Machinists*, 372 U.S. at 693 n.17 (quoting *Sola Elec. Co. v. Jefferson Elec. Co.*, 317 U.S. 173, 176 (1942)).

It bears emphasizing, however, that the inquiry is different than in a "private right of action case" (*Jackson Transit*, 457 U.S. at 20), where the Court focuses on Congress's intention to confer a private right and a private remedy. *See Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). In those cases, the Court considers whether the suing party "can bring [a] suit at all." *Jackson Transit*, 457 U.S. at 21. In contrast, in situations where a statute contemplates a contract, "it is reasonable to conclude that Congress expected the . . . agreement . . ., like ordinary contracts, to be enforceable by private suit upon a breach." *Id.* at 20-21. The central issue instead is "whether Congress intended such contract actions to set forth federal, rather than state, claims." *Id.* at 21; *see also id.* at 30 (Powell, J., concurring) ("Congress here provided for the making of contracts that it must have intended to be enforced. The Court thus identifies the question correctly as whether Congress intended those contracts to be enforced in federal court.").

B. Empire Seeks to Enforce a Contract Contemplated by FEHBA

Empire seeks enforcement of contractual obligations contemplated by a federal statute and thus meets the threshold requirement for invoking the Court's case law on federal claims to enforce a contract. Empire brought suit for "Breach of Obligations under [a] FEHBA Plan" and sought monetary and declaratory relief. J.A. 40-48. More specifically, Empire seeks enforcement of the reimbursement terms contained in the Service Benefit Plan's Statement of Benefits. These terms mandate that enrollees who obtain recoveries from third parties for injuries, after having received benefits from the Plan for those same injuries, shall repay the Plan the benefits it has provided. *See supra* p. 6.

The Statement of Benefits is part of the contract between OPM and BCBSA establishing the Service Benefit Plan. The OPM-BCBSA contract provides that "[t]he Carrier shall provide the benefits as described in the Certified Brochure Text found in Appendix A" and that "[t]he Carrier's subrogation rights, procedures and policies, including recovery rights, shall be in accordance with the Certified Brochure Text." J.A. 89, 92; *see also id.* 115, 118-19. The Certified Brochure Text, in turn, is the contract's terminology for the "detailed statement of benefits offered" that "[e]ach contract . . . shall contain." 5 U.S.C. § 8902(d).

Empire's suit to enforce the reimbursement provisions of the Statement of Benefits, therefore, is a suit to vindicate the terms of a contract – namely, the OPM-BCBSA contract. OPM enters the contract to provide health benefits for its employees; the Blue Cross and Blue Shield entities agree to administer the Plan and to provide the specified benefits; and, "[b]y enrolling or accepting services under th[e] contract, Members [*i.e.*, federal employees] are obligated to all terms, conditions, and provisions of th[e] contract." J.A. 90, 116.

This contract, in turn, is one for which FEHBA expressly provides. FEHBA authorizes OPM to "contract with qualified carriers offering plans described by section 8903 or 8903a." 5 U.S.C. § 8902(a). Section 8301(1) then directs that OPM "may contract for . . . [o]ne Government-wide plan . . . under which payment is made by a carrier under contracts with [providers]," known as the "Service benefit plan." *Id.* § 8903(1). Likewise, again, the statute also expressly delineates that a "statement of benefits" shall exist and be contained in each FEHBA contract, including the contract for the Service Benefit Plan. *Id.* § 8902(d); *see also id.* § 8907(b).

As a consequence, Empire's suit is not merely one to enforce a contract, but one to enforce a contract specifically "set forth" in FEHBA. *Jackson Transit*, 457 U.S. at 15. In fact, while OPM may enter contracts for a number of other categories of FEHBA plans, such as "Employee organization plans" or "Comprehensive medical plans," the Service Benefit Plan is one of just two health benefits plans individually identified in the statute. 5 U.S.C. § 8903(3)-(4). The other is the "Indemnity benefit plan," *id.* § 8903(2), for which OPM currently has not entered a contract. *See Oversight of Federal Employees Health Benefits Program and the Federal Long Term Care Insurance Program: Hearing Before the Subcomm. on Civil Service and Agency Organization of the Committee on Government Reform*, 108th Cong. 9 (2004) (Stmt. of Dan G. Blair, OPM).

C. Congress Intended That the Obligations in FEHBA Contracts Be Federal in Nature

Because FEHBA contemplates the OPM-BCBSA contract and its Statement of Benefits, the Court must next determine whether Congress intended the contract to be a "creation[ ] of federal law and bound to the statute and its policy." *Int'l Ass'n of Machinists*, 372 U.S. at 692. That is, for jurisdictional purposes, the dispositive issue is whether Congress expected FEHBA contracts to create obligations that are federal in na-

ture. Here, FEHBA's statutory scheme, in particular its pre-emption provision and the policies it embodies, point to one conclusion: "Congress intended that federal rather than state law would govern [the] contract." *Jackson Transit*, 457 U.S. at 28 n.10.

1. FEHBA Establishes a Pervasively Federal Regime for the Creation and Regulation of FEHBA Contracts

In examining whether Congress expected FEHBA contracts to create federal obligations, the place to "begin [is] with the language of the statute itself." *Id.* at 23. Viewing first the statute as a whole, it sets forth a detailed, self-contained framework for the creation, financing, and regulation of FEHBA plans. Nowhere does it envision state regulation.

As already noted, the OPM-BCBSA contract and the Statement of Benefits themselves have their origin in FEHBA's statutory provisions, with the statute both authorizing OPM to enter contracts to create plans and mandating a statement of benefits in those contracts. The statute also sets out many other mandatory, as well as optional, terms to be included in FEHBA contracts, such as non-discrimination terms, reinsurance provisions, terms allowing for coverage for various types of medical services, and cost-containment measures. *See* 5 U.S.C. § 8902(c), (f), (n); *id.* § 8904. In decreeing the creation, structure, and content of FEHBA contracts, Congress nowhere in the statute mentioned any role for the states.

The Plan's funding is exclusively delineated in FEHBA. *See supra* pp. 6-7. Overall, the Plan is financed solely with federal funds, except for enrollee contributions. *See* 5 U.S.C. § 8906. And these funds are held in the U.S. Treasury in an account that Empire and other Blue Cross and Blue Shield entities can tap periodically to pay benefits on an ongoing basis. *See supra* pp. 6-7.

FEHBA delegates the oversight and regulation of FEHBA plans to a single, *federal* authority – OPM. In addition to authorizing OPM to enter FEHBA contracts, the statute tasks OPM with selecting benefits terms that "the Office finds necessary or desirable" (which then are reflected in a statement of benefits). 5 U.S.C. § 8902(d). Hence, the reimbursement terms at issue in this case are themselves terms that, by statute, fell within OPM's discretion to include. The statute also delegates to OPM responsibility for providing information about plans and their terms to enrollees "as may be necessary to enable the individual[s] to exercise an informed choice among the types of plans" (5 U.S.C. § 8907(a)); setting "reasonable minimum standards" for plans and for carriers (*id.* § 8902(e)); establishing enrollment criteria for federal employees and annuitants (*id.* §§ 8905, 8913(a)); determining premium rates (*id.* § 8906); auditing each plan's contract performance (*id.* § 8910); terminating contracts (*id.* § 8902(e)); and "prescrib[ing] regulations necessary to carry out [FEHBA]." *Id.* § 8913. Significantly, Congress vested OPM – and that agency alone – with the authority to adjudicate individual disputes over benefits and to insist in the contracts it enters that carriers agree to pay benefits the agency finds are due "in an individual case." *Id.* § 8902(j).

The "bare language" of the statute, then, indicates a legislative scheme that is pervasively federal in character. *Jackson Transit*, 457 U.S. at 23. From cradle to grave, FEHBA plans and the contracts creating them are subject to enumerated federal statutory requirements and federal regulation, not state control. This is not surprising, since FEHBA is designed to provide a fringe benefit to federal employees. The regulation and protection of the federal government's own workforce is hardly an area that one logically would expect Congress to delegate to the states, especially when the associated financial burdens are borne by the federal government. The statute's

general provisions and framework reflect that logic: they create "contracts [that] are creatures of federal law." *Id.*

2. FEHBA's Preemption Provision Signals a Broad Congressional Intent That FEHBA Contracts Shall Preempt State Law

The most specific indication of Congress's intent on the role of state law is FEHBA's preemption section, and it was this statutory provision that consumed much of the discussion in both the majority and dissenting opinions below. Like all of the other provisions in FEHBA, the preemption clause too envisions a regime dominated by federal, not state, law; it therefore is further strong indication that Congress anticipated FEHBA disputes would be controlled by federal law.

a. The Preemption Provision Is the Product of Repeated Congressional Efforts to Limit the Operation of State Law

Though FEHBA did not contain a preemption section when enacted in 1959, Congress added one in 1978. As originally adopted, the section stated:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans *to the extent that such law or regulation is inconsistent with such contractual provisions.*

5 U.S.C. § 8902(m)(1) (1994) (emphasis added).

With this provision, Congress intended "to establish uniformity in benefits and coverage under the Federal employees' health benefits program." S. Rep. No. 95-903, at 2, *reprinted in* 1978 U.S.C.C.A.N. 1412, 1413. Prior to 1978, the Comptroller General had documented for Congress the manner in which states had begun to impose requirements with respect to FEHBA plans. *See id.* at 3, 1978 U.S.C.C.A.N. at 1414 (refer-

encing Report of Comptroller General entitled "Conflicts Between State Health Requirements and Contracts of the Federal Employee Health Benefits Carriers"). The states' activities particularly threatened inequities for FEHBA plans operating in more than one state, given that each enrollee pays the same premium. Absent preemption, the operation of state law could "be expected to result" in "increased premium costs to both the Government and enrollees, and [a] lack of uniformity in benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 95-282, at 4 (1977).

At the same time, with the final phrase of the original preemption provision, Congress preserved state law that was not "inconsistent" with FEHBA contract provisions relating to benefits and coverage. Congress expected that language, however, to be interpreted narrowly. It was simply meant to leave intact state regulatory legislation unrelated to benefits, such as "a State's authority to control the licensing of health practitioners," S. Rep. 95-903, at 4, 1978 U.S.C.C.A.N. at 1415, and "certain taxes or insurance reserve requirements." H.R. Rep. No. 95-282, at 5; *see also* 124 Cong. Rec. S14,591 (daily ed. Aug. 25, 1978) (Stmt. of Sen. Stevens) (provision would "preempt[ ] State law as applied to such Federal employee health benefit contracts," while leaving the states to be the "judge as to who is and who is not qualified to provide medical care").

Congress's contemporaneous actions with respect to other legislation also confirm the broad preemptive intent of FEHBA's original preemption clause. Four years earlier, Congress had enacted the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, governing employee benefits for employees of private employers. ERISA, from its inception, has contained a preemption section providing for the preemption of "any and all State laws insofar as they may now or hereafter relate to any employee benefit

plan." 29 U.S.C. § 1144(a). The Court has repeatedly viewed ERISA's preemption clause as "clearly expansive," though, of course, not to the point of "'indeterminacy.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (quoting *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). Having used similar "relates to" language in FEHBA's preemption clause so soon after enacting ERISA, Congress presumably had a similarly expansive intent with respect to the displacement of state law in FEHBA. If anything, Congress's actions in 1978 on FEHBA implied an even greater scope for preemption than ERISA. Whereas ERISA contains a clause saving insurance regulation from preemption, *see* 29 U.S.C. § 1144(b)(2), Congress took pains in FEHBA to preempt state law that "relates to *health insurance* or plans" where state law is inconsistent with FEHBA contract provisions. 5 U.S.C. § 8902(m)(1) (1994) (emphasis added).

Nonetheless, several courts interpreted FEHBA's preemption clause narrowly. *E.g.*, *Goepel v. Nat'l Postal Mail Handlers Union*, 36 F.3d 306 (3d Cir. 1994); *Arnold v. Blue Cross & Blue Shield of Tex., Inc.*, 973 F. Supp. 726 (S.D. Tex. 1997); *Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Tex., Inc.*, 924 F. Supp. 67 (W.D. Tex. 1996); *Kincade v. Group Health Servs. of Okla., Inc.*, 945 P.2d 485 (Okla. 1997). Some of these decisions involved "complete preemption," a jurisdictional doctrine under which a statute with "extraordinary preemptive power" can "convert[ ] an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987). Resting on the FEHBA preemption clause's closing phrase preserving state law not "inconsistent" with FEHBA contract terms, these courts found that FEHBA did not completely preempt state law for jurisdictional purposes. The decisions rejected analogies to ERISA – which this Court had previously said does completely preempt state law (*see Metropolitan Life*, 481 U.S. at 65-66) – on the

ground that the ERISA preemption clause contains no proviso exempting from preemption state laws not inconsistent with the statute. *See, e.g., Goepel*, 36 F. 3d at 312 & n.7; *Arnold*, 973 F. Supp. at 731-32; *Transitional Hosps.*, 924 F. Supp. at 70.

These decisions allowing state courts to resolve FEHBA disputes sent Congress back to the drafting table. In 1998, it amended FEHBA's preemption clause to take out the final phrase requiring inconsistency between state law and FEHBA contract provisions. As the preemption clause now reads, FEHBA contract provisions on benefits and coverage preempt state law merely if the state law "relates to health insurance or plans." 5 U.S.C. § 8902(m)(1) (2000). Congress explained that the amendment "broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997) (J.A. 24). Alluding to its concern over the court decisions on complete preemption, Congress said: "The amendment confirms the intent of Congress . . . that FEHB program contract terms which relate to the nature or extent of coverage or benefits *completely displace* State or local law relating to health insurance or plans." *Id.* at 16 (J.A. 25) (emphasis added). In the same vein, Congress added that the "change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." *Id.* at 9 (J.A. 24).

The end result of Congress's efforts is a preemption provision designed to preempt all state law – not just inconsistent state measures – pertaining to benefits, coverage, and benefits payments. The timing of the provision's 1998 amendment, coming after a series of decisions rejecting complete preemption, shows that Congress intended the preemption section not only to thwart the application of state law but also to provide a federal jurisdictional basis for lawsuits concerning benefits and coverage. Likewise, the amendment's timing indicates that the courts should read FEHBA's preemption clause at least as

broadly as ERISA's. As it now stands, the critical "relates to" language at the end of FEHBA's preemption provision replicates ERISA's, except that its preemptive scope extends not just to a state law that "relates to" plans, but even to one that "relates to" health insurance.

Because FEHBA's preemption clause broadly preempts state law, it provides overwhelming evidence that Congress did not intend for disputes involving FEHBA contracts "to be governed by state law applied in state courts." *Jackson Transit*, 457 U.S. at 29. The issue is Congress's intent as to the nature of the obligations in FEHBA contracts. The text and lengthy history of the preemption clause show that Congress intended FEHBA benefits matters to be an exclusively federal domain and that the states, and state courts, had no role to play.

One other point about the preemption provision warrants specific mention: from the start, the clause has made the "terms of any contract" under FEHBA the trigger for preemption. The preemption provision therefore gives the contract terms themselves "'the imprimatur of . . . federal law,'" since Congress has provided that they – like a statute or regulation – may supersede state law. *Int'l Ass'n of Machinists*, 372 U.S. at 692 (quoting *Railway Dep't v. Hanson*, 351 U.S. 225, 232 (1956)). Consequently, Congress did not just intend for FEHBA contracts to be "creatures of federal law," it made them be tantamount to federal law. *Jackson Transit*, 457 U.S. at 23. With the contracts themselves having the force and effect of federal law, it follows that Congress would have anticipated that suits to enforce the contractual obligations would be federal in nature.

b. The Court of Appeals Misconstrued Congress's Intent with Respect to the Preemption Provision

The court of appeals disagreed that FEHBA's preemption provision should be read expansively. It said that the preemption clause's reference to a state law that "relates to health

insurance or plans" includes only state laws specifically targeted at health insurance or plans. In its view, the preemption clause does not cover "laws of general application," such as contract laws, even when those laws "are used in a given case to 'construe or enforce' FEHBA plans." Pet. App. 16a (quoting Raggi, J., dissenting (Pet. App. 39a)). Because the preemption provision supposedly does not cover contract laws, and those would be the laws necessary for Empire's enforcement of the reimbursement provisions, the court of appeals believed the "'critical factor' of congressional intent" did not favor "federal jurisdiction over Empire's claims." *Id.* at 48a.

The court of appeals' cramped construction cannot be reconciled with the history and development of FEHBA's preemption clause. Congress's actions show that it expected the courts to give the provision an expansive sweep, and it amended the provision when courts had begun to do otherwise. It instructed that both inconsistent *and* consistent state law shall be preempted, with only state laws at the periphery of plan administration – such as practitioner licensing, financial reserves, and certain tax laws – surviving. It would turn Congress's intent on its head now to construe the preemption clause as covering only those measures addressed expressly to insurers and health plans, leaving the provision powerless to block the vast majority of state laws, including state contract, tort, and other common law doctrines, consumer protection measures, and even anti-discrimination measures that might compel specific benefits for specified categories of individuals. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 88-89 (1983) (involving effort to use New York's general human rights statute to mandate benefits under an ERISA plan).

Furthermore, the court of appeals' interpretation is contradicted by this Court's decisions construing ERISA's similar preemption language. From the very start in its ERISA jurisprudence, the Court has held that the ERISA preemption clause's reference to state laws that "relate to . . . plans" is not

limited to "only state laws specifically designed to affect employee benefit plans." *Id.* at 98. In this regard, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court straightforwardly ruled that ERISA "pre-empts state common law tort and contract actions," again "emphasiz[ing] that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'" *Id.* at 43, 47-48 (quoting *Shaw*, 463 U.S. at 98); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200, 219 n.6 (2004) (reaffirming holding in *Pilot Life* that the "causes of action were pre-empted").

To the same effect, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 135 (1990), the Court held that ERISA preempts "a state common law claim" in which an employee alleged that he was wrongfully terminated because of the employer's desire to avoid paying pension benefits. The Court held: "Because the court's inquiry must be directed to the plan, th[e] . . . cause of action 'relate[s] to' an ERISA plan"; "there simply is no cause of action if there is no plan." *Id.* at 140. The Court also explained that Congress preempted state common law causes of action to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law." *Id.* at 142. Without broad preemption, plans would be exposed to a "[p]articularly disruptive . . . potential for conflict in substantive law" because state courts "might develop different substantive standards applicable to the same employer conduct." *Id.* That would be "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Id.*

It would make no sense to hold that ERISA's preemption clause can extend to laws of general application but that FEHBA's cannot. Such a conclusion would make futile Congress's recent effort amending FEHBA's preemption clause. As the Ninth Circuit has explained, "Congress amended the [FEHBA preemption] statute after numerous courts had found that FEHBA did not completely preempt state laws, but ERISA did. Thus, Congress replaced FEHBA's original preemption

clause with ERISA's." *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 399 (9th Cir. 2002). The concern for uniform plan administration that justifies ERISA's preemption provision is at least equally present in FEHBA.

The court of appeals drew a divide between ERISA and FEHBA because, in its view, "ERISA is significantly more comprehensive than FEHBA, in that it contains multiple preemption provisions and a detailed civil enforcement scheme." Pet. App. 19a; *see* 29 U.S.C. § 1132 (ERISA's enforcement section). But it is, in fact, FEHBA that establishes more comprehensive federal regulation. FEHBA regulates the plans it creates from formation to termination and interposes a federal agency – OPM – to supervise all aspects of a carrier's administration of a plan. By contrast, ERISA largely leaves employers free to establish and terminate health benefits plans as they see fit, but sets forth fiduciary obligations in the event an employer does create a plan; also, the Labor Department, while responsible for oversight of ERISA, does not play an in-depth role comparable to OPM under FEHBA. *See Travelers*, 514 U.S. at 651; *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

In the end, the court of appeals' determination that FEHBA does not preempt state laws of general application produces the anomalous result that state law plays a greater role in regulating the federal government's own health benefits plans than it does for private employer plans governed by ERISA. "[I]f Congress intended to preempt state law when regulating private employers, it would be strange to leave regulation to the individual states when the employer is the United States itself." *Blue Cross & Blue Shield v. Cruz*, 396 F.3d 793, 799 (7th Cir. 2005), *pet. for cert. filed*, No. 04-1657 (June 6, 2005). The exact opposite should be true: Congress logically would want federal law to play a greater role in regulating federal employees than in regulating private employees.

Finally, the court of appeals felt constrained to limit the reach of FEHBA's preemption provision because it mistakenly believed its analysis was governed by a "presumption against federal preemption." Pet. App. 15a. What the court of appeals was referring to is the presumption that "'in fields of traditional state regulation the historic police powers of the States [are] not to be superseded by [a] Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* at 18a (quoting *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847, 850 (9th Cir. 2002)) (brackets in original). That presumption, however, applies only in areas of *traditional* state regulation. Where the relationship state law would regulate "originates from, is governed by, and terminates according to federal law," then "no presumption against pre-emption obtains." *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 347-48 (2001); *accord Boyle v. United Techs. Corp.*, 487 U.S. 500, 507-08 (1988) ("the fact that the area in question is one of unique federal concern changes what would otherwise be a conflict that cannot produce pre-emption into one that can"). Here, the states have no interest in the regulation of fringe benefits for the federal government's own employees, and the relationships created among the United States, the FEHBA carrier, and federal employees with respect to the provision of health benefits should begin, continue, and end according to federal law.

The court of appeals, in sum, seriously misconstrued FEHBA's preemption clause. Interpreted correctly, the provision evinces a broad intention that FEHBA contract terms shall preempt state laws, whether general in application or specific to health plans. As such, the clause provides specific statutory indicia that Congress expected federal law to govern disputes involving a FEHBA contract's obligations and thus that suits to enforce those obligations present federal, not state, claims.[2]

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[2] The court of appeals correctly recognized (*see* Pet. App. 14a n.7) that another provision of FEHBA, 28 U.S.C. § 8912, was not unfa-

D. This Case Satisfies the Criteria for Treating a Claim to Enforce Contractual Obligations as a Federal Claim

Empire's case, then, satisfies the criteria described in *Jackson Transit* and similar cases for treating a contract enforcement action as a federal claim. Empire's complaint seeks enforcement of a contract contemplated by a federal statute. Indeed, FEHBA not only "contemplates" the contract at issue here, it also explicitly describes that contract in the text of the statute. Further, every indication in FEHBA and its history is that Congress expected FEHBA contracts to be governed exclusively by federal law. The statute creates no role for the states and broadly preempts state law, including the types of state laws that otherwise would be used to enforce FEHBA reimbursement terms. In the legislative history, Congress even went so far as to say that it wanted claims stemming from FEHBA benefits to be tried in the federal courts rather than state courts.

This analysis conforms to the approach of the Seventh Circuit in *Cruz* and of Judge Raggi in dissent here. As Judge Raggi observed in dissent, Congress in providing for FEHBA con-

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vorable to federal jurisdiction over Empire's claim. That provision states that "the district courts of the United States have jurisdiction, concurrent with the United States Court of Claims," over suits "against the United States founded on [FEHBA]." As the court of appeals stated: "Of course, the grant of federal jurisdiction over one category of claims does not necessarily strip federal courts of their jurisdiction over another category of claims." *Id.* (citing *Verizon Md., Inc. v. Pub. Serv. Comm'n*, 535 U.S. 635 643 (2002)). In reality, Congress had a very limited purpose in mind with respect to § 8912. It "was enacted merely to enable making the United States a party to a court action in a district court, which would otherwise have been barred by the $10,000 limitation on suits against the United States in such court. 28 U.S.C. § 1346(b)." *Rosano v. United States*, 9 Cl. Ct. 137, 144 (1985), *aff'd*, 800 F.2d 1126 (Fed. Cir. 1986).

tracts surely intended that the parties would be able to enforce the contractual provisions. *See* Pet. App. 29a-30a, 43a. Therefore, "it is reasonable to conclude that FEHBA contracts are enforceable through common-law breach of contract actions." *Id.* at 29a-30a. That conclusion necessarily poses the question whether such contract actions present "federal, rather than state, claims." *Jackson Transit*, 457 U.S. at 21. Judge Raggi correctly found that the answer to that question flows from FEHBA's preemption provision, noting that it "contemplates that the coverage and benefits terms of FEHBA plans will always be construed *only* by reference to uniform federal common law." Pet. App. 40a. Given this displacement of state law, "it logically follows that Congress was thereby authorizing courts to look to federal common law both to construe those rights uniformly and to resolve insurance carriers' FEHBA claims." *Id.* at 43a.

The Seventh Circuit in *Cruz* similarly found that the express preemption clause, coupled with FEHBA's contemplation of health benefits contracts, inexorably leads an action to enforce the reimbursement provision of a FEHBA contract into federal court. "With no explicit statutory cause of action on which to rely and with state law preempted, Congress's clear intent to have uniform subrogation rules per the terms of the FEHBA-created contract require a 'judicially-crafted cause of action.'" *Cruz*, 396 F.3d at 800 (citation omitted); *see also Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 77 (4th Cir. 1993).

The court of appeals' majority in this case reached the wrong result largely because of its misguided reading of the preemption provision and its failure to acknowledge the pervasive federal nature of the entire FEHBA regulatory scheme, particularly the contract at issue here. Accordingly, the Court should reverse the court of appeals, hold that Empire has raised a federal claim, and find that Empire's case therefore "arises under" federal law.

II. EMPIRE'S COMPLAINT RAISES A FEDERAL CLAIM BECAUSE IT SEEKS ENFORCEMENT OF A GOVERNMENT CONTRACT AND INVOLVES A PROGRAM FOR WHICH CONGRESS HAS DEMANDED UNIFORM LEGAL RULES

Even if the *Jackson Transit* line of cases had never been decided, the conclusion that Empire has raised a federal claim also would follow from the general principles this Court has developed for applying federal common law to disputes in which important federal interests are at stake. When litigation under nationwide programs touches on significant federal interests, this Court has consistently held that the federal courts should resolve such disputes by applying federal law. Moreover, when the programmatic interests call for a uniform rule, the Court has held that the federal courts should develop federal rules of decision, rather than applying state law. The principles developed in these cases demonstrate, independent of the *Jackson Transit* analysis, that the court of appeals erred in finding that no federal jurisdiction exists over this case.

A. Federal Law Governs Litigation Involving Important Federal Programmatic or Contractual Interests, and the Federal Courts Determine the Content of That Law Independent of State Law if Uniformity Is Required

1. Litigation of Important Federal Programmatic Interests Is Governed by Federal Law

A well-settled line of precedent establishes that it is generally inappropriate for state law and state courts to be the arbiter of important federal interests that are related to federal programs. The seminal case is *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943), where this Court held that federal law applied to a suit by the United States against a bank to recover funds paid on a forged check. The Court explained that "[t]he rights and duties of the United States on commercial paper which it issues are governed by federal rather than local law." *Id.* at

366. Thus, even though there was no rule of decision prescribed by federal statute, the Court declared that "it is for the federal courts to fashion the governing rule of law according to their own standards." *Id.* at 367.

The Court then addressed a related issue, whether the content of the federal law should reflect the otherwise applicable state law. The Court explained that there existed a need for a uniform federal rule that made it inappropriate for state law rules to play a part. The government's issuance of commercial paper "is on a vast scale" nationwide, and therefore application of state law "would subject the rights and duties of the United States to exceptional uncertainty." *Id.* There would be "great diversity in results" because of the "vagaries of the laws of the several states." *Id.* Because the "desirability of a uniform rule is plain," the Court held that the federal courts must resolve such cases by "fashioning federal rules" to resolve "these federal questions." *Id.*; *see generally* Henry J. Friendly, *In Praise of* Erie – *And of the New Federal Common Law*, 39 N.Y.U. L. Rev. 383, 410, 411 (1964) (*Clearfield Trust* establishes that "the courts of the United States may formulate a rule of decision" when federal interests are at stake and create "a body of federal law on those issues where national uniformity is demanded").

The Court has since applied the principles of *Clearfield Trust* in a variety of settings, emphasizing the need for federal courts to adjudicate issues that arise under important government programs. In *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 726 (1979), for example, the Court held that the priority of liens stemming from federally guaranteed lending programs "must be determined with reference to federal law" because "federal law governs questions involving the rights of the United States arising under nationwide federal programs." *See also United States v. Standard Oil Co.*, 332 U.S. 301, 307 (1947) (invoking the "federal judicial power to deal with . . . essentially federal matters" in adjudicating a tort suit brought

by the United States to recover for the loss of a soldier's services). Similarly, in *United States v. Little Lake Misere Land Co.*, 412 U.S. 580 (1973), the United States brought suit to quiet title to a parcel of land acquired in connection with a wildlife refuge program authorized by federal statute, which the Court identified as a land acquisition "arising from and bearing heavily upon a federal regulatory program." *Id.* at 592. The Court ruled that federal law governed under the "first" holding of *Clearfield Trust* – namely, a "recognition of federal judicial competence to declare the governing law in an area comprising issues substantially related to an established program of government operation." *Id.* at 593 (internal quotation omitted).

With respect to the second inquiry of *Clearfield Trust*, whether state law contributes to the content of the federal law to be applied or is completely displaced, the most important factor is the need for a uniform rule of decision. "[F]ederal programs that 'by their nature are and must be uniform in character throughout the Nation' necessitate formulation of controlling federal rules." *Kimbell Foods*, 440 U.S. at 728 (quoting *United States v. Yazell*, 384 U.S. 341, 354 (1966)); *see also Boyle v. United Techs. Corp.*, 487 U.S. 500, 508 (1988) ("where the federal interest requires a uniform rule, the entire body of state law applicable to the area conflicts and is replaced by federal rules"). "Conversely, when there is little need for a nationally uniform body of law, state law may be incorporated as the federal rule of decision." *Kimbell Foods*, 440 U.S. at 728. Hence, in *Kimbell Foods* itself, although the Court held that federal law applied, it went on to hold that the federal rule of decision should follow state law because "uniformity" was not contemplated for the administration of a federal program that involved individually negotiated loans. *Id.* at 730; *see also O'Melveny & Myers v. FDIC*, 512 U.S. 79, 88 (1994) (refusing to displace state law because "the interest in uniformity" is "not even at stake").

More often, however, the Court has determined that state law must be displaced when litigation affecting important federal interests calls for the federal courts to apply federal law. In *Standard Oil*, the Court rejected any use of state law because the issues were "appropriate for uniform national treatment" and should not "vary in accordance with the different rulings of the several states." 332 U.S. at 311, 310. In *Little Lake Misere*, the Court held that the state rule at issue could not apply because it was "hostile to the interests of the United States." 412 U.S. at 597. In *West Virginia v. United States*, 479 U.S. 305, 309 (1987), the Court held that a "single nationwide rule [governing prejudgment interest on disaster relief debts] would be preferable to one turning on state law" because "the incorporation of state law would not give due regard to the federal interest" embodied in the statute. *See Illinois v. City of Milwaukee*, 406 U.S. 91, 105 n.6 (1972) (pointing to "an overriding federal interest in the need for a uniform rule of decision"); *accord Banco Nacional de Cuba v. Sabbatino*, 376 U.S. 398, 421-27 (1964).

2. The Case For Application of Federal Law Is Particularly Strong When the Suit Involves Enforcement of a Government Contract

The applicability of federal law under *Clearfield Trust* principles is particularly evident when the federal interest at stake is enforcement of a government contract. The Court has broadly stated that disputes involving the "validity and construction of contracts through which the United States is exercising its constitutional functions, their consequences on the rights and obligations of the parties, and the titles or liens which they create or permit, all present questions of federal law not controlled by the law of any State." *United States v. County of Allegheny*, 322 U.S. 174, 183 (1944), *overruled on other grounds, United States v. City of Detroit*, 355 U.S. 466 (1958); *see also Boyle*, 487 U.S. at 504 ("obligations to and rights of the United States under its contracts are governed

exclusively by federal law"); *West Virginia v. United States*, 479 U.S. at 308-09; *Kimbell Foods*, 440 U.S. at 726-27; *Nat'l Metropolitan Bank v. United States*, 323 U.S. 454, 456 (1945). As the Court explained in *United States v. Seckinger*, 397 U.S. 203, 209-10 (1970) (footnote omitted), "federal law controls the interpretation of [a federal] contract" because "the contract was entered into pursuant to authority conferred by federal statute and, ultimately, by the Constitution."

Little Lake Misere is particularly instructive on this point. In finding federal law applicable there to a suit to quiet title, the Court remarked that it had "consistently" ruled that "dealings which may be 'ordinary' or 'local' as between private citizens raise serious questions of national sovereignty when they arise in the context of a specific constitutional or statutory provision; *particularly is this so when transactions undertaken by the Federal Government are involved*, as in this case." 412 U.S. at 592 (emphasis added). With respect to the specific need for federal law, the Court emphasized both the broader federal programmatic interest that it sought to uphold and that the government was seeking to enforce its own contract: "We deal with the interpretation of a land acquisition agreement (a) explicitly authorized, though not precisely governed, by the Migratory Bird Conservation Act and (b) to which the United States itself is a party." 412 U.S. at 594; *see also id.* at 604.

Important federal programmatic interests, particularly those embodied in a government contract, require application of federal law even when the United States is not a party to the litigation. Thus, in *Boyle*, the Court held that it was necessary to apply federal law to a wrongful death action brought against a government contractor in order to protect the federal interest in its procurement program. 487 U.S. at 504. Applying the principles of *Clearfield Trust*, the Court concluded that federal common law displaced state law and provided government contractors with a defense against suits based on design defects

that were called for by the government's contract specifications.

The Court in *Boyle* framed its inquiry in terms of preemption, observing that "[i]n most fields of activity" it "has refused to find federal pre-emption of state law in the absence of either a clear statutory prescription . . . or a direct conflict between federal and state law." *Id.* at 504. The Court added, however, that where "uniquely federal interests" are at stake, it has also found state law "pre-empted and replaced" by "federal common law" even in the absence of a statutory preemption clause or a direct conflict between state and federal law. *Id.*

The Court applied a two-part analysis to conclude that the suit in *Boyle* fell into this third category of cases in which it was appropriate to apply federal common law in place of state law. First, the Court found that the litigation implicated a "uniquely federal interest" – namely, the government's "interest in the procurement of equipment." *Id.* at 504-06. The litigation would "directly affect the terms of Government contracts" because imposing liability on government contractors who adhered to contract specifications would impel contractors either to reject the government's proposed design or to raise their price. *Id.* at 507.

Second, the Court concluded that it was appropriate to displace state law to safeguard the federal interest. In the absence of any express preemption by statute, the Court looked to whether there existed a "significant conflict" between the federal interest and the operation of state law. *Id.* In *Boyle*, the state-imposed duty of care on which the tort suit was founded conflicted with the duty imposed by the federal contract specifications. *See id.* at 509. Because those specifications reflected an exercise of the federal government's discretion in military procurement, the Court concluded that imposing liability for adhering to the specifications would conflict with the federal policy embodied in the discretionary function exception of the Federal Tort Claims Act. *Id.* at 511-12. Accordingly, it ruled

that federal law must displace, not incorporate, state law by including a defense for federal contractors that would insulate them from liability associated with exercises of the government's discretionary functions. *Id.* at 512-13.[3]

The Court noted in *Boyle* that the situation in the case before it was at the "opposite extreme" (*id.* at 509) from *Miree v. DeKalb County*, 433 U.S. 25 (1977), where state law governed a private damages suit in which the plaintiffs claimed to be third-party beneficiaries of a contractual promise made by the county to the federal government that it would not allow a garbage dump adjacent to an airport. *Boyle*, 487 U.S. at 509. In *Miree*, there was no conflict between the federal interest and state law, and the federal interest was "'too speculative [and] far too remote . . . to justify the application of federal law.'" *Id.* at 506 (*quoting Miree*, 433 U.S. at 32-33). Moreover, in *Miree* the Court had found that the lawsuit would "have no direct effect upon the United States or its Treasury" (433 U.S. at 29) and that Congress had "chosen not to" "displace state law" in the underlying legislative scheme (*id.* at 32). Therefore, in contrast to *Boyle*, the general principles for applying federal law when important federal programmatic interests are at stake did not come into play in *Miree* despite the plaintiffs' attempt to rely upon a federal contract.

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[3] The form of the Court's analysis deviated slightly from the formulation of *Clearfield Trust* and its progeny. The Court framed the inquiry in terms of "displacement of state law," rather than "displacement of federal-law reference to state law for the rule of decision." 487 U.S. at 508 n.3. Thus, although its "conflict" analysis mirrored the second *Clearfield Trust* inquiry, the Court did not specifically answer the first inquiry – that is, whether federal law would have applied if the Court had concluded that state law was not displaced.

B. Empire's Claim Seeks Enforcement of a Government Contract and Implicates a Nationwide Program Requiring Uniformity

These precedents all require that Empire's suit be heard by a federal court applying federal law. Empire's action seeks enforcement of a government contract. The reimbursement terms contained in the Statement of Benefits are part of the OPM-BCBSA contract. *See supra* p. 6. Therefore, this case falls squarely within the general rule that "federal law controls the interpretation of [a federal] contract" (*Seckinger*, 397 U.S. at 209), and there is no reason to depart from that rule.

Even apart from the case being one to enforce a government contract, important interests of the United States are directly at issue in FEHBA reimbursement suits. That is because reimbursement recoveries inure to the benefit of the United States. Reimbursement collections are credited to the U.S. Treasury, where the premium funds are held. *See supra* p. 7. The FEHBA carrier has no interest in those funds; it does not obtain a "cut" of the recovery. Rather, its only profit under its plan is through a service charge allowance that the contracting parties negotiate. The reimbursement amounts add to the funds available to pay benefits, with any surplus in the funds being available to the United States for its purposes under the FEHBA program. *See supra* p. 7. Under these circumstances, the carrier is, in effect, the government's agent in reimbursement matters. The OPM-BCBSA contract requires Empire to make a "reasonable effort" to collect reimbursement, and that effort is for the government's benefit. J.A. 95, 125.[4]

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[4] This same analysis shows that the court of appeals erred in rejecting Empire's argument based on *Seckinger*, *County of Allegheny*, and the other authorities holding that government contracts are subject exclusively to enforcement under federal law. The court of appeals thought the rule applies only when the United States is a party to the suit or at least when the action is "to determine the rights of the

For these reasons, there should be little doubt that this case involves important federal programmatic interests – "uniquely federal interests" in the language of *Boyle* – akin to those that the Court has repeatedly recognized as appropriately governed by federal law. The suit has a direct financial effect on the government, and is essentially one on behalf of the government. Even the Second Circuit below did not seriously question that this case satisfied the "uniquely federal interest" prong of the *Boyle* analysis. Judge Sotomayor expressly did not address the issue (Pet. App. 6a), and Judge Sack stated that this aspect of the *Boyle* analysis had been met (*id.* at 25a). Under the "first holding" of *Clearfield Trust*, then, a federal court applying federal law should hear Empire's claim.

Because the issue here is federal court *jurisdiction*, that conclusion suffices to resolve this case without proceeding to the second *Clearfield Trust* inquiry. It is true that the focus of the *Clearfield Trust* line of cases was the substantive rule of decision, not jurisdiction. In most cases, the United States was the plaintiff, which established federal jurisdiction under 28 U.S.C. § 1345; in other cases, there already existed diversity jurisdiction. But as this Court has observed, the conclusions that federal law governed the claims in those cases are relevant to jurisdiction in a case like this one, where jurisdiction is invoked under 28 U.S.C. § 1331. *See Int'l Ass'n of Machinists, AFL-*

United States"; Empire supposedly "seeks to vindicate *its* rights against another private party." Pet. App. 47a (emphasis added). However, the court of appeals failed to recognize that a reimbursement recovery inures to the government's benefit and that, as a result, the enrollee's reimbursement obligation is owed, in effect, to the United States. Though Empire is the suing party, it is the rights of the United States, and obligations to it, that are being determined. *Cf. Edelman v. Jordan*, 415 U.S. 651, 663 (1974) (action subject to government's defenses, such as sovereign immunity, even if government is not a party, where government "is the real, substantial party in interest").

CIO v. Central Airlines, Inc., 372 U.S. 682, 693 n.17 (1963) ("Although these decisions did not involve federal jurisdiction as such, . . . they are suggestive since they hold federal law determinative of the merits of the claim").

If the contract enforcement claim is governed by federal law, it necessarily follows that the claim can be brought in federal court. "It is well settled that [28 U.S.C. § 1331] 'will support claims founded upon federal common law as well as those of a statutory origin.'" *Nat'l Farmers Union Ins. Cos. v. Crow Tribe of Indians*, 471 U.S. 845, 850 (1985) (quoting *Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972)); *see also Jackson Transit Auth. v. Local Div. 1285, Amalgamated Transit Union, AFL-CIO-CLC*, 457 U.S. 15, 21 n.6 (1982); 15 Daniel R. Coquillette *et al.*, Moore's Federal Practice § 103.32[4], at 103-60.1 (3d ed. 2005) ("When federal common law governs a case, that case necessarily presents a federal question within the subject matter jurisdiction of the federal court system just as if the case were controlled by federal statute").[5]

In any event, the conditions for displacement of state law in accordance with the second *Clearfield Trust* holding are clearly met here as well. It is unnecessary for the Court to guess whether Congress would regard a uniform rule of decision as important to the FEHBA program. The need for uniformity, and the attendant displacement of state law, is unquestioned because Congress has specifically addressed the issue. Con-

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[5] Because Empire's complaint, under this analysis, is founded on federal common law, it raises a federal claim. But even if the cause of action were created by state law, it would still be subject to federal question jurisdiction. In *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 125 S. Ct. 2363, 2367 (2005), the Court recently reconfirmed that "in certain cases federal question jurisdiction will lie over state-law claims that implicate significant federal issues." It is incontrovertible that the enforcement of OPM's nationwide FEHBA contract "implicate[s] significant federal issues"; the court of appeals, again, essentially conceded as much. Pet. App. 6a, 25a.

gress included a preemption clause in FEHBA, and then amended that clause because of concern that it was not being given a sufficiently broad preemptive effect. The intent of the preemption clause, as already noted, was to "confirm" that FEHBA contract terms "completely displace" state law and to ensure that "national plans" can "offer *uniform* benefits and rates." H.R. Rep. No. 105-374, at 9, 16 (1997) (emphasis added) (J.A. 24, 25); *see supra* p. 24. Thus, this case falls squarely within the parameters of the cases applying the second holding of *Clearfield Trust*.

The court of appeals, however, focused exclusively on the *Boyle* formulation and rejected the application of federal law because of Empire's alleged failure to meet "the conflict prong of *Boyle*" by "demonstrat[ing] that the operation of New York state law creates an 'actual, significant conflict'" with federal interests. Pet. App. 6a-7a. Its conclusion, however, rests on a faulty understanding of the *Boyle* analysis and of the prior line of authority that it synthesizes.

The "actual, significant conflict" inquiry of *Boyle* is a straw-man in this case because it is not a prerequisite to application of federal law when Congress has affirmatively demonstrated its intent to displace state law. The Court addressed the conflict issue in *Boyle* only because of the absence of the more common justification for displacing state law – "a clear statutory prescription" for "federal pre-emption of state law" (487 U.S. at 504). Similarly, the absence of any expression of congressional intent was critical to the Court's ruling in *O'Melveny & Myers v. FDIC*, 512 U.S. 79, 87-88 (1994), that federal common law could not apply because there was no need for uniformity and no conflict with state law. Before embarking on the conflict inquiry the Court emphasized that, "[i]n answering the central question of displacement of California law, we of course would not contradict an explicit federal statutory provision." *Id.* at 85; *see also Kimbell Foods*, 440 U.S. at 728 (inquiry into state law "frustrat[ing] specific objectives of the

federal programs" arises only if state law is not displaced because of a need for uniformity); *Little Lake Misere*, 412 U.S. at 593 n.10 (the strongest case for displacement of state law is "where Congress explicitly displaces state law in the course of exercising clear constitutional regulatory power over a particular subject matter").

The "conflict prong" of the *Boyle* analysis, ultimately, is just a form of preemption inquiry that is unnecessary when preemption is expressly provided by statute. *See* Pet. App. 27a-28a (Raggi, J., dissenting); Martha A. Field, *The Legitimacy of Federal Common Law*, 12 Pace L. Rev. 303, 316 (1992) (federal common law must be applied "if federal law preempts state law"); Erwin Chemerinsky, *Federal Jurisdiction* § 6.2, at 372 (4th ed. 2003) (summarizing *Boyle* as an inquiry into whether "federal law is deemed to preempt state law," which can be shown either through a conflict between state and federal law "or if there is a clear congressional intent to preempt state law"). The ultimate "issue that must be determined in each instance is what heed Congress intended to have paid to state law." Friendly, 39 N.Y.U. L. Rev. at 410. Where Congress has spoken in the statute, it is unnecessary to try to divine its intent indirectly by examining areas of conflict between state law and federal interests. Therefore, state law must be displaced here irrespective of a specific conflict between New York law and federal policy.

But even if the express preemption clause did not obviate the need for a conflict inquiry, there exists the necessary conflict in this case. *Boyle* noted that "the conflict with federal policy need not be as sharp as that which must exist for ordinary preemption when Congress legislates in a field which the States have traditionally occupied." 487 U.S. at 507 (quotation marks omitted). Here, the conflict is substantial. Applying the varied rules of the 50 states would conflict with the uniformity principle that the preemption provision embodies. In furtherance of that principle, the OPM-BCBSA contract expressly states that

the Blue Cross and Blue Shield entities administering the Plan "shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under th[e] contract." J.A. 95, 125. Uniformity is particularly critical in a nationwide plan such as the Service Benefit Plan, the one nationwide FEHBA plan expressly described in FEHBA and currently extant. If the Plan's subrogation policy varied from state to state, "the practical effect is that federal employees in different states paying the same premiums would not be required to repay benefits after recovery from third parties according to the same rules." *Blue Cross & Blue Shield v. Cruz*, 396 F.3d 793, 799 (7th Cir. 2005), *pet. for cert. filed*, No. 04-1657 (June 6, 2005). "Federal employees in different states would have different reimbursement obligations and hence different net benefits." *Id.*

This scenario is precisely what would occur if state law governed actions for reimbursement under a FEHBA contract. There is considerable variation in subrogation law across the country, and many states have strong anti-subrogation rules that prohibit or severely limit a carrier's ability to obtain reimbursement. *See* Patricia G. Tobin, *The Rawlings & Assocs. National Subrogation Law Manual 1998*, at 51-53 (1997). OPM has final authority over the selection of benefits terms in its contract with BCBSA (*see* 5 U.S.C. § 8902(d)), and the consistency in subrogation mandated there reflects a federal policy – one that furthers Congress's intent that FEHBA plans offer "uniform benefits." H.R. Rep. No. 105-374, at 16 (J.A. 24). Applying varied state laws to reimbursement actions thus presents a "conflict with federal policy" that meets any requirement imposed by the second prong of the *Boyle* analysis. 487 U.S. at 507.

CONCLUSION

The decision of the court of appeals should be reversed.

Respectfully submitted,

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In The

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,

Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR RESPONDENT

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QUESTION PRESENTED

Without clear Congressional authorization, should this Court (1) expand the subject matter jurisdiction of the federal courts to include all claims arising under the terms of a private contract providing health benefits to federal employees, even where the terms at issue do not involve health coverage or benefits and (2) find that those terms supersede and preempt state laws and regulations, even where there is no demonstrated conflict between federal and state law.

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In The

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No. 05-200

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,

Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF FOR RESPONDENT

STATUTORY PROVISIONS INVOLVED

The Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914, provides in pertinent part:

5 U.S.C. § 8902(m)(1):

The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8912:

The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter.

SUMMARY OF ARGUMENT

The Petitioner and the United States as amicus curiae argue that federal subject matter jurisdiction should be found to exist over, not only this simple reimbursement claim, but, without limitation, virtually all claims arising under any of the terms contained in the Statement of Benefits drafted by the Petitioner pursuant to its contract with the Federal Office of Personnel Management ("OPM"), as authorized by the Federal Employees Health Benefit Act ("FEHBA"). They additionally argue that all of the terms in the Statement of Benefits are, in effect, federal laws that should supersede and preempt state laws and regulations.

In essence they argue that such sweeping federal jurisdiction and preemption should be invoked by this Court because of general policy considerations and based upon what they believe to have been the intent of Congress in the drafting and adopting of the FEHBA statute.

In the abstract, accepting their view that the decision in this case will affect the entire health insurance benefit system provided by the U.S. government to its nine million federal employees nationwide, their policy argument for one unified federal judicial forum to determine all claims arising under this benefit plan, and for total preemption, becomes persuasive, indeed compelling.

There are multiple reasons, however, why these arguments must fail.

In the first place, this case does not involve, nor has it been shown in the record that this case will affect, the entire health insurance benefit system provided to federal employees, It does not involve a question of coverage or benefits and there is no showing in the record that a decision in this case will, in any manner or to any extent, affect the coverage or benefits provided to federal employees. Even in the limited context of the Petitioner's reimbursement claim, there is no evidence presented to show that the lower court's denial of jurisdiction will in any way, even marginally, affect this health benefit plan or the U.S. Treasury.

To put it simply, there is no showing that an adjudication of this reimbursement claim in state court, as opposed to federal court, will result in any detriment to the Petitioner or the U.S. Treasury.

Second, if Congress had intended, after due deliberation and consideration of the policy objectives behind the FEHBA statute, to provide for one unified federal judicial forum to hear all claims arising under any contracts authorized by FEHBA, it certainly could have expressly done so, as it has done with other statutes.

Congress did not do so. It did not confer "exclusive" jurisdiction in the federal courts to hear all "claims arising out of this chapter". What Congress did, by way of the express and specific language in FEHBA, was to explicitly limit federal district court jurisdiction for claims arising under FEHBA to actions or claims "against the United States".

The statutory jurisdictional language in FEHBA is express, clear and specific. As such, a strict construction of the statute requires a finding that federal jurisdiction is limited to "claims against the United States and no one else".

Furthermore, by comparing this specific and unambiguous statement with the jurisdictional statements contained in similar statutes, such as the Employee Retirement Income Security Act ("ERISA"), *29 U.S.C. § 1001 et seq.*, there can be no mistaking Congressional intent to, when it wanted to, expand jurisdiction under certain statutes and to limit jurisdiction in others, such as FEHBA.

Third, if Congress had intended for all of the terms of this health benefit plan to supersede and preempt state laws and regulations, it could have also expressly done so.

What Congress did do was to limit the preemption clause in FEHBA to the terms of the contract relating only to "the nature, provision or extent of coverage or benefits".

Fourth, there is no compelling reason why this Court, without specific Congressional authorization, should expand upon the express jurisdiction provided for in the statute, or preempt state law with the terms of the Petitioner's contract; no reason to displace state law and substitute a judicially fashioned federal common law relative to all FEHBA claims.

Indeed, there are compelling reasons why jurisdiction should not be extended to include claims that do not involve issues of coverage or benefits, such as this reimbursement claim.

As stated, this case does not involve a question of coverage or benefits, nor is it shown that the decision in this case will, in any manner or to any extent, affect the coverage or benefits provided to federal employees. Additionally, the intent of Congress, to ensure that the application of state laws do not limit or affect the health coverage and benefits provided to federal employees, has already been addressed by the preemption provisions of the statute.

Under the test enunciated by this Court in *Boyle v. United Techs. Corp., 487 U.S. 500 (1988),* this Court has already provided a means to litigate coverage and benefit disputes under FEHBA in the federal district courts. If it is shown that there is a "significant conflict between an identifiable federal policy or interest and the operation of state law" or that the application of state law would "frustrate specific objectives" of FEHBA (so as to limit or deny health coverage or benefits provided to a federal employee), federal law would pre-empt state law to resolve any such conflict in favor of the federal employee.

Fifth, and perhaps most importantly (when viewing this case from a policy standpoint), expanding federal court jurisdiction over simple reimbursement claims such as this, will serve to hurt, most dramatically and in a practical way, the very group of people that the Congress meant to protect by the passage of the FEHBA statute, namely their own federal employees. At the same time, there is no evidence to show that expanding the original jurisdiction of the United States district courts to include reimbursement claims will result in any practical benefit to the Petitioner or to the U.S. government.

ARGUMENT

Whether this case is decided based upon (1) a strict construction of the express language contained in the FEHBA statute, and/or (2) an evaluation of Congressional intent, and/or (3) general policy considerations, the result is the same: the decision of the court of appeals should be affirmed.

I. A STRICT CONSTRUCTION OF THE STATUTORY LANGUAGE IN FEHBA SHOWS THAT THE FEDERAL DISTRICT COURTS DO NOT HAVE JURISDICTION OVER THIS ACTION AND FURTHER THAT STATE LAW SHOULD NOT BE PREEMPTED.

Without question, it is Congress, in the first instance, that has the constitutional authority to define the jurisdiction of the lower Federal courts, *Keene Corporation v. United States, 508 U.S. 200, 207*, and to preempt state laws that conflict with federal statutes, *New York v. U.S., 505 U.S. 144.*

When dealing with questions of federal jurisdiction and preemption, this Court has always begun the inquiry with an examination of the statutory language itself.

The starting point for interpreting a statute is the language of the statute itself, *Consumer Product Safety Comm'n v. GTE Sylvania, Inc., 447 U.S. 102, 108,* and the analysis of jurisdiction and preemption in this case must begin with the language of the statute, *Bread Political Action Committee v. Federal Election Commission, 455 U.S. 577; Dawson Chemical Co. v. Rohm & Haas Co., 448 U.S. 176.*

A. JURISDICTIONAL STATEMENT

Jurisdictional provisions are to be construed with precision and with fidelity to the terms by which Congress has expressed its wishes, *Palmore v. United States, 411 U.S. 389.* "Due regard for the rightful independence of state governments requires that the federal courts scrupulously confine their own jurisdiction to the precise limits which the statute has defined", *Finley, v. United States, 490 U.S. 545, 553.* Once the lines are drawn, limits on federal jurisdiction must be neither disregarded nor evaded, *Keene Corporation, 508 U.S. at 207, citing to Owen Equipment & Erection Co. v. Kroger, 437 U.S. 365, 374.*

The jurisdictional statement in the FEHBA statute, *5 U.S.C. § 8912,* clearly and unambiguously states that the federal district courts have original jurisdiction over claims "*against the United States*" *(emphasis supplied).*

This language is clear and unambiguous. It does not say that "the district courts shall have jurisdiction (exclusive or otherwise) over civil actions under this chapter", or that "the district courts shall have jurisdiction over civil actions to enforce the terms of a health benefit plan or contract authorized by this chapter". Nor does the statute say that "the district courts shall have jurisdiction over civil actions by or against enrollees in the health plan", or "civil actions that inure to the benefit of the United States", or "civil actions to enforce subrogation and/or reimbursement rights".

Nor does the statute define jurisdiction in a manner to reach any defendant other than "the United States". This statute clearly and succinctly says "*against the United States*" and this Court, in an interpretation of an identical phrase contained in the Federal Tort Claim Act, *28 U.S.C. § 1346(a)*, has previously said

that the phrase means "*against the United States and no one else*". *See, Finley, 490 U.S. at 552 (emphasis supplied); see also Point II (B)(3) herein.*

Strictly construed and applying this Court's interpretation of the phrase "against the United States", there is no jurisdiction in the federal district courts for this claim.

B. PREEMPTION STATEMENT

If a statute contains an express preemption clause, the Court must in the first instance focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent, *Sprietsma v. Mercury Marine, 537 U.S. 51; CSX Transp., Inc. v. Easterwood, 507 U.S. 658.*

FEHBA contains an express preemption clause which provides in pertinent part that the "terms of any contract under this chapter *which relate to the nature, provision, or extent of coverage or benefits* ... shall supersede and preempt any State or local law ...", *5 U.S. C. 8902(m)(1), (emphasis supplied).*

As with the jurisdictional language, this preemption language is clear and unambiguous. It does not say that all the "terms of any contract under this chapter shall supersede and preempt any State or local law ...". Instead, Congress specifically inserted the limiting words " which relate to the nature, provision, or extent of coverage or benefits".

These words, "coverage" and "benefits", have been defined by the Congress in various statutes, see e.g., 42 U.S.C. 300gg-91(b)(1), 5 U.S.C. 8904(a), and those definitions do not include, or even mention, subrogation or reimbursement claims.

Under normal rules of statutory interpretation, "identical words used in different parts of the same statute are generally presumed to have the same meaning", *IBP, Inc. v. Alvarez, 546 U.S. ___ (2006) (slip op., at 11)*. As such, when the preemption clause uses the specific words "coverage or benefits", it must be presumed that it means "benefits consisting of medical care" such as "Hospital benefits, Surgical benefits (etc.)".

Strictly construed, the statute only provides for preemption when the issue involves "coverage or benefits", not for reimbursement claims or other terms of the Petitioner's Statement of Benefits not involving "coverage or benefits".

Furthermore, it is of paramount importance that this Court, when it evaluates and decides jurisdictional issues or preemption issues, examine the language of the statute itself and set forth clear rules of interpretation, so that Congress may know the effect of the language it adopts. *See, Finley, 490 U.S. at 556.*

By using the words "against the United States", the Congress needs to know that it is limiting federal court jurisdiction to cases "against the United States and no one else". Likewise, by using the phrase "which relate to the nature, provision, or extent of coverage or benefits", the Congress needs to know that preemption will not occur unless the application of state laws or regulations affect "coverage or benefits".

While the courts may refer to a statute's legislative history and evaluate Congressional intent to resolve a statutory ambiguity, where the statutory language is clear, there is no need for such inquiry, *Toibb v. Radloff, 501 U.S. 157 at 162.* If the statute's language is plain, the sole function of the court is to enforce it according to its terms, *U.S. v. Ron Pair Enterprises, Inc., 489 U.S. 235 at 241.*

Where the terms of a statute are clear and unambiguous, judicial inquiry is complete, *Hughes Aircraft Company v. Jacobson, 525 U.S. 432, 438*; *Rubin v. United States, 449 U.S. 424, 430,* and the Court's task is an easy one, *English v. General Elec. Co., 496 U.S. 72.*

II. CONGRESS INTENDED FOR FEDERAL JURISDICTION AND PREEMPTION TO BE LIMITED

It is beyond dispute that only Congress is empowered to grant and extend the subject matter jurisdiction of the federal judiciary, and that the federal courts are not to infer a grant of jurisdiction absent a clear legislative mandate, *Rice v. Railroad Co., 66 U.S. 358, Dalehite v. United States, 346 U.S. 15, 30-31.*

Likewise, it will not be presumed that a federal statute was intended to preempt state law unless there is a clear manifestation of Congressional intent to do so, since the exercise of federal supremacy is not lightly to be presumed, *Schwartz v. State of Tex., 344 U.S. 199.* Congressional intent to supersede state laws must be clear and manifest, *English, 496 U.S. 72.*

Consideration of whether preemption will violate the Supremacy Clause, *U.S.C. Const. Art. VI, cl. 2,* starts with the basic assumption that Congress did not intend to displace state law, *Building and Const. Trades Council of Metropolitan Dist. V. Associated Builders and Contractors of Massachusetts/Rhode Island, Inc., 507 U.S. 218; Maryland v. Louisiana, 451 U.S. 725* and a Court interpreting a federal statute pertaining to a subject traditionally governed by state law will be reluctant to find preemption, unless there is a clear and manifest purpose of Congress to do so, *CSX Transp., Inc., 507 U.S. 658*; *Healy v. Ratta, 292 U.S. 263.*

Indeed, "in order to guarantee the division of governmental responsibilities between the national government and the States that was intended by the Framers of the Constitution ... the national government should be deferential to the States when taking action that affects the policymaking discretion of the states and should act only with the greatest caution ...", *Ex. Ord. No. 13132, Aug. 4, 1999, 64 F.R. 43255.*

> "(Federal) agencies shall construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking *only when the exercise of State authority directly conflicts with the exercise of Federal authority* under the Federal statute *or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law*. Any regulatory preemption of State law shall be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations are promulgated." *Id at Sec. 4 (emphasis supplied).*

A. LEGISLATIVE HISTORY

Congress enacted FEHBA in 1959 to provide "a wide range of hospital, surgical, medical and related benefits designed to afford federal employees full or substantially full protection against expenses of both common and catastrophic illness or injury", *H.R. Rep. 86-957, 3.* Initially it contained a jurisdictional statement that granted original jurisdiction to the federal district courts for "any civil action or claim against the United States founded upon this legislation", *H.R. Rep. 86-957, 15.* However, it did not contain any preemption provisions.

In 1978, Congress amended FEHBA to add a preemption provision, *5 U.S.C. § 8902(m)(1)*. In doing so, Congress stated that:

> "H.R. 2931, as amended, guarantees that the provisions of health benefits contracts made under Chapter 89, of Title 5, U.S.C. *concerning benefits or coverage*, would preempt any state and/or local insurance laws and regulations which are inconsistent with such contracts. *Such a preemption, however, is purposely limited and will not provide insurance carriers under the programs with exemptions from state laws and regulations governing other aspects of the insurance business ...", S. Rep. 95-903, 1978 U.S.C.C.A.N. 1413; H.R. Rep. No. 95-282, 1977 at 3 (emphasis supplied).*

In furtherance of that stated goal, the first preemption provision contained the limiting words "which relate to the nature, provision, or extent of coverage or benefits".

It is also significant that, in this amendment, no change was made to the jurisdictional language that expressly limited federal court jurisdiction to actions "against the United States".

In 1998, Congress again amended FEHBA, primarily to address "the debarment of health care providers engaging in fraudulent practices" and to provide for continued health insurance for certain individuals, *see H.R. Rep. No. 105-374 (J.A. 6-26)*. The preemption provision was also amended, only to the extent of deleting the phrase "to the extent that such law or regulation is inconsistent with the provisions of the Federal employee' health benefits contract", *5 U.S.C. § 8902(m)(1)*.

It is again significant that when FEHBA was amended in 1998, Congress again did not change the limiting jurisdictional language in the statute. Nor did that amendment delete the limiting language "which relate to the nature, provision, or extent of coverage or benefits" from the amended preemption provision.

This legislative history presents strong evidence that Congress considered preemption and jurisdictional issues when drafting and amending this legislation and that Congress made the conscious decision to, not only limit the jurisdiction of the district courts, but also to limit the preemptive effect of the FEHBA statute to issues involving "coverage or benefits".

Indeed, the stated goal of the preemption provision was not to preempt every issue addressed in a FEHBA plan, but to "purposely" limit preemption to issues of "coverage or benefits".

B. COMPARISON WITH OTHER STATUTES

In evaluating the intent of Congress, it is also appropriate to examine and compare the jurisdictional statements and preemption provisions in FEHBA with the provisions contained in similar statutes, along with the policy objectives behind those statutes.

In the first instance, it is significant that Congress made no provision of any kind in FEHBA for subrogation or reimbursement, as it has in other statutes. See, e.g., *42 U.S.C. § 2651-2653* (authorizing the Veterans Administration under the Medical Care Recovery Act to recover benefits from beneficiaries who have obtained tort recoveries); *42 U.S.C. 1395y* (providing for reimbursement to the Social Security Administration). The first and only reference to subrogation or

reimbursement claims is made in the Statement of Benefits written, not by Congress, but by the Petitioner, as part of its contract.

Such an omission by Congress, in stark contrast to the elaborate subrogation and reimbursement provisions contained in other statutes, shows that Congress did not intend to authorize remedies that it simply forgot to incorporate expressly. *See, Mertens v. Hewitt Assoc., 508 U.S. 248 at 254.*

1. ERISA

Unlike FEHBA, the Employee Retirement Income Security Act ("ERISA"), provides in pertinent part that the Federal district courts "shall have *exclusive* jurisdiction of civil actions under this subchapter", *29 U.S.C. § 1132(e)(1) (emphasis supplied).*

This statute is recognized as a comprehensive statute with a clear grant of extended, and "exclusive", subject matter jurisdiction in the Federal courts. Not only does its jurisdictional statement contain the word "exclusive", the entire legislative scheme behind ERISA establishes an intention by Congress to "provide a uniform regulatory regime", including "expansive pre-emption provisions" and an "integrated enforcement mechanism", "which are intended to ensure that employee benefit plan regulation is 'exclusively a Federal concern' ", *Aetna Health Inc., v. Davila, 542 U.S. 200.*

To further those goals, Congress expressly provided in the ERISA statute for extensive regulatory requirements and for appropriate remedies and access to the federal courts. Congress expressly used the word "exclusive" when defining jurisdiction and included in ERISA an expansive preemption provision, *see*

ERISA § 514, 29 U.S.C. § 1144.

In stark contrast to ERISA, the FEHBA statute does not, in its jurisdictional statement, contain the word "exclusive". Nor is the FEHBA preemption clause nearly as expansive as the clause in ERISA, containing the above noted limiting language.

2. CIVIL RIGHTS ACT

Unlike FEHBA, the Civil Rights Act ("CRA"), provides in pertinent part that "each United States district court ... *shall have jurisdiction of actions brought under this subchapter*", *42 U.S.C. § 2000e-5(f)(3) (emphasis supplied).*

In a manner similar to the analysis here, this Court made a comparison of the jurisdictional language in the CRA to the jurisdictional language in ERISA.

In an opinion delivered by Justice Stevens, this Court stated that "Unlike a number of statutes in which Congress unequivocally stated that the jurisdiction of the federal courts is exclusive, (the Civil Rights Act) contains no (such) language ... The omission of any such provision is strong, and arguably sufficient evidence that Congress had no such intent.", *Yellow Freight System, Inc. v. Donnelly, 494 U.S. 820.*

Presumptively, if Congress had intended for FEHBA jurisdiction to be "exclusive", as it did in ERISA, it could have specifically said so. Likewise, if Congress had intended for FEHBA jurisdiction to include all "actions brought under this subchapter", as it did in the CRA, it also could have specifically said so, rather than indicate that jurisdiction would only be in "a civil action or claim against the United States".

The same can be said for preemption. If Congress had intended for FEHBA, and the terms of contracts authorized by FEHBA, to totally preempt state laws and regulations, it could have said so. If it had intended to specifically authorize the government and it's contract providers to assert subrogation and/or reimbursement claims to recover FEHBA benefits from a third-party tortfeasor or from a federal employee's personal injury recovery, as it did with Veterans benefits and Social Security benefits, it certainly could have included such a comprehensive regulatory provision in FEHBA. It did not.

Paraphrasing a partly concurring and partly dissenting opinion by Justice Thomas, joined by Justice Souter:

> "Had the (Congress) wished to pre-empt all state laws governing (all of the provisions in the Petitioner's Statement of Benefits), (it) could have more explicitly defined the regulatory 'subject matter' to be covered ... To read (otherwise), however, negates Congress' desire that state law be accorded 'considerable solicitude' ", *see CSX Transportation, Inc., 507 U.S. 658 at 679.*

These omissions are strong, and arguably sufficient evidence that Congress had no intent to expand subject matter jurisdiction under FEHBA or to totally preempt state law with the terms of the Petitioner's plan.

3. FEDERAL TORT CLAIMS ACT

Most instructive is this Court's analysis and interpretation of the jurisdictional statement contained in the Federal Tort Claims Act ("FTCA"), *28 U.S.C. § 1346(a).*

In virtually identical language to FEHBA, the FTCA provides for original jurisdiction in the district courts for a "civil action or claim *against the United States*" *(emphasis supplied)*.

In 1989, in an opinion delivered by Justice Scalia, this Court found that the statutory text of the FTCA "defines jurisdiction in a manner that does not reach defendants other than the United States", concluding that when a statute says *"against the United States"*, it means *"against the United States and no one else"*, *Finley, 490 U.S. at 552 (emphasis supplied)*.

This judicial interpretation of the phrase "against the United States" and its application to this case are particularly compelling.

In the first instance, "Considerations of *stare decisis* are particularly forceful in the area of statutory construction, especially when a unanimous interpretation of a statute has been accepted as settled law for several decades", *IBP, Inc., 546 U.S. ___ (2005) (slip op. at 10)*.

Furthermore, when Congress amended FEHBA in 1998, it could hardly been unaware of this Court's judicial interpretation of the phrase "against the United States" as adopted in *Finley* in 1989. "And when judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the (Congressional) intent to incorporate its ... judicial interpretations as well." *See, Merrill Lynch v. Dabit, 547 U.S. ___ (2006) (slip op. at 13) (citations and internal quotation marks omitted)*.

When Congress expressly inserted the phrase "against the United States" into the FEHBA statute and when it left that

phrase intact while amending other sections of FEHBA, it could hardly been unaware that it meant "against the United States and no one else".

There is nothing in the legislative history or background of FEHBA to indicate that the Congress intended FEHBA to be expansive, analogous to ERISA; or that Congress intended to extend jurisdiction under FEHBA to all claims arising under its provisions, analogous to the CRA; or that Congress intended for FEHBA jurisdiction to reach any defendant except the United States, as this Court so succinctly stated in *Finley* in 1989.

To the contrary, the use or omission by Congress of specific words, such as "exclusive" and "against the United States", is strong evidence that Congress considered jurisdictional issues in enacting these statutes and did not hesitate expressly to confer, or limit, federal jurisdiction where it found it necessary or advisable to do so. Likewise, the use of the specific words "which relate to the nature, provision, or extent of coverage or benefits" is strong evidence that Congress considered preemption issues when drafting this legislation and made the intentional decision to limit the preemptive reach of FEHBA.

Absent a clear manifestation of Congressional intent to do otherwise, a clear legislative mandate, it must be presumed that jurisdiction in the federal courts under FEHBA is limited to cases "against the United States" and that FEHBA preemption is limited to issues which relate to "coverage or benefits". To do otherwise would violate the intent of Congress, not to mention raise serious concerns regarding the implications of the Supremacy Clause, *U.S.C. Const. Art. VI, cl. 2.*

In regard to the Supremacy Clause, it must be noted that there was discussion in this case by the Court of Appeals as to whether the private contract terms in the Petitioner's Statement of Benefits can, constitutionally, be considered to be the "supreme Law of the Land", so as to supersede and displace state laws. *See, Memorandum Opinion, appendix to the Petition for Certiorari, 1a; 396 F.3d 136 at 143.*

The Respondent believes that the preemption of settled state law by the private contract terms contained in the Statement of Benefits promulgated and written by this private contractor, and not by the Congress, may, in fact, implicate the Supremacy Clause and be unconstitutional. Only the laws, as written by Congress, can operate as the "supreme Law of the Land" for the purposes of preemption under the Supremacy Clause. However, in that the constitutional issue did not form the basis for the denial of jurisdiction in either the District Court or the Court of Appeals, it will not be addressed here at any length.

Suffice it to say that there is a danger in allowing the terms of a private contract, not written by Congress, to preempt and displace the laws of any State, even where that contract is entered into pursuant to the general authority of a federal statute. This is particularly true where the terms of that private contract are decided upon, and written, by any number of private entities, such as Empire, or any other entity with whom OPM enters into an agreement.

III. FEDERAL COMMON LAW DOES NOT APPLY TO THIS BREACH OF CONTRACT SUIT

It is well settled that there is no federal general common law, *Erie R. Co. v. Tompkins, 304 U.S. 64, 78.* The courts will only create federal common law where (1) the case implicates a

"uniquely federal interest", and (2) a "significant conflict exists between an identifiable federal policy or interest and the operation of state law", *Boyle, 487 U.S. at 504.*

Such cases are "few and restricted" and are "limited to situations where there is a significant conflict between some federal policy or interest and the use of state law", *O'Melveny & Myers v. Federal Deposit Insurance Corporation, 512 U.S. 79, 87 (citations and internal quotations omitted).*

A. PETITIONER HAS FAILED TO SHOW A "UNIQUE FEDERAL INTEREST"

As a threshold matter, a case must implicate "uniquely federal interests" for federal common law to apply, *Boyle, 487 U.S. at 504.*

While at first glance the Petitioner's argument, that this case involves an area of uniquely federal interest, seems to have merit, upon closer scrutiny, it becomes apparent that this reimbursement claim is too far removed from the purposes and objectives of FEHBA to call for the wholesale creation of a new body of federal common law.

It is manifest from a reading of FEHBA and its legislative history, that Congress intended for federal employees to be guaranteed certain minimum levels of health coverage and benefits that could not be limited or restricted by individual state laws or regulations. That is the "unique federal interest" underlying the FEHBA statute and is clearly stated. Indeed, the legislative history specifically provides as an example conflicting state laws that do not provide coverage for chiropractic services, *S. Rep. 95-903 at 2.*

This case, however, does not involve any issues related to coverage or benefits, but rather involves other aspects of the insurance business that the statute leaves to the authority of the states. This claim for reimbursement by a benefit plan administrator, the Petitioner, from its own beneficiary, pursuant to the terms of its contract, is not an area of "unique federal interest", but is rather a claim already well provided for under the common law of con.racts.

Additionally, the Petitioner's argument that applying state law would undermine the ability of the U.S. government to recover funds disbursed under this health program and would conflict with program objectives is unsupported. There is no showing that the United States has any immediate interest in the specific amount the Petitioner may be entitled to recover in this action and there is no evidence presented to demonstrate that the United States would, in any appreciable way, be affected by state adjudication of this claim. Furthermore, there has been no showing that deference to state laws regarding this reimbursement claim would have any demonstrable effect on the U.S. Treasury or the objectives behind the FEHBA program, other than the appellant's and amicus counsel claiming it's so.

There is no "unique federal interest" in this litigation. Because this litigation is among private parties and no substantial rights or obligations of the United States hinge on its outcome, creation of a new body of federal common law is particularly inappropriate.

B. PETITIONER HAS FAILED TO SHOW AN "IDENTIFIABLE FEDERAL POLICY OR INTEREST" THAT CONFLICTS WITH STATE LAW

Even assuming that "uniquely federal interests" are shown, federal common law only applies where a "significant conflict exists between an identifiable federal policy or interest and the operation of state law", *O'Melveny, 512 U.S. at 87; Boyle, 487 U.S. at 504.*

The only argument presented by the Petitioner and by the United States as amicus curiae to attempt to identify some federal policy or interest at stake in this case are their generalized calls for uniformity. However, neither the Petitioner, nor the United States, make any specific showing that New York law in any way conflicts with any claimed need for uniformity. *See Atherton v. F.D.I.C., 519 U.S. 213.*

In numerous cases, this Court has rejected similar attempts to rely upon vague assertions about the need for uniformity. *See, Atherton, 519 U.S. 213; O'Melveny, 512 U.S. at 88; United States v. Kimbell Foods, Inc., 440 U.S. 715 at 730.* " A mere federal interest in uniformity is insufficient to justify displacing state law in favor of a federal common law rule", *B.F. Goodrich v. Betkoski, 112 F.3d 88, 90 (2d Cir. 1997), cert. denied sub nom; Zollow Drum Co. v. B.F. Goodrich Co., 524 U.S. 926; see O'Melveny, 512 U.S. at 88.*

While uniformity of law might facilitate the Petitioner's nationwide litigation of these reimbursement claims, eliminating state-by-state research and reducing uncertainty, if the avoidance of those ordinary consequences qualified as an identifiable federal interest, the federal courts would be awash in federal common-law rules, *O'Melveny, 512 U.S. at 88; see also, United States v. Yazell, 382 U.S. 341, 347, n. 13.*

The Petitioner and the United States as amicus curiae have failed to show an "identifiable federal interest" and their

generalized and unsupported calls for uniformity are insufficient to justify the creation of a federal common law rule.

C. PETITIONER HAS FAILED TO IDENTIFY ANY CONFLICTING STATE LAW

It was upon this failure of proof that the Court of Appeals based its decision:

> "Empire has failed to demonstrate that the operation of New York state law creates an actual, significant conflict with those interests ... Tellingly, Empire's briefs on appeal fail to mention a single state law or state-imposed duty that runs contrary to the federal interests asserted in this case", *Empire HealthChoice Assurance, Inc. v. McVeigh, 396 F.3d 136 at141 (citations and internal quotation marks omitted).*

Even assuming that this dispute implicates a uniquely federal interest and further assuming that the Petitioner's generalized call for national uniformity states a sufficient federal interest, which it does not, federal common law would still not apply because the Petitioner has not shown that any state law would, even potentially or marginally, conflict with any such federal policy or interest.

No such state law is even identified. Not only does the Petitioner fail to make any showing that New York law conflicts with any federal interest, it makes no allegations of any kind as to how any New York law would decide this case and fails to explain why, or how, a federal common law rule would or should differ from New York law.

There is no state law of any kind referred to anywhere in the Brief For Petitioner (indeed, there is no mention of any allegedly conflicting state law anywhere in the record of this case), and while the Petitioner claims that there is "considerable variation in subrogation law across the country", such an unsubstantiated claim is, in any event, irrelevant to this case.

The inadequacy of this argument is highlighted by the fact that this case does not involve a subrogation claim (a claim by an insurer against a third-party tortfeasor), but is rather a "reimbursement" claim by this plan administrator against its own beneficiary.

The Petitioner's failure to identify the existence of any state laws relating to "reimbursement" claims or to show the effect of any such laws is fatal to its argument.

Even assuming, as it claims, that there is "considerable variation in subrogation law across the country", the Petitioner fails to show how any such unnamed laws would be relevant to this case or would, in any manner or to any extent, conflict with any claimed need for uniformity or any federal interest.

Proof of an actual, significant conflict between a federal interest and state law must be "specifically shown" and not generally alleged, *Atherton, 519 U.S. 213, see O'Melveny, 512 U.S. at 87-88*, as a "precondition for recognition of a federal rule of decision", *O'Melveny, 512 U.S. at 87, citing to Kamen v. Kemper Financial Services, Inc., 500 U.S. 90, 98; Boyle, 487 U.S. at 508; Kimbell Foods, 440 U.S. at 728.*

As stated by this Court, in a unanimous opinion delivered by Justice Scalia:

> "Such cases are, as we have said in the past, few and restricted, limited to situations where there is a significant conflict between some federal policy or interest and the use of state law. Our cases uniformly require the existence of such a conflict as a precondition for recognition of a federal rule of decision", *O'Melveny, 512 U.S. 79, 87.*

D. PETITIONER HAS FAILED TO SHOW THAT THE APPLICATION OF STATE LAW WOULD HAVE ANY DIRECT AND SUBSTANTIAL EFFECT ON THIS HEALTH PLAN OR UPON THE U.S. TREASURY

Beyond bare assertions, the Petitioner fails to submit any evidence to show that there would be any direct or substantial effect upon the United States, or its Treasury, or this health plan, by the application of any state law, including the laws of New York. Even the United States as Amicus Curiae, with presumably scores of accountants at its beck and call, has produced no evidence or statistics or analysis to show how state law would, in any manner or to any extent, affect the Treasury.

It would seem to be a relatively simply matter, had the Petitioner chosen to do so, to demonstrate to the court below how many reimbursement claims are brought each year; how much money is involved in these claims and how the application of state law to these reimbursement claims would significantly alter the net annual outcome to the U.S. Treasury. No such information was provided and this Court should not be asked to speculate on the possibility that such a substantial effect exists.

This Court has repeatedly held that state laws "should be overridden by the federal courts only where clear and substantial interests of the National Government ... will suffer major damage if state law is applied", *Yazell, 382 U.S. at 352; Boyle, 487 U.S. at 518 (in dissent).*

Where there is no direct and substantial effect on the United States or its Treasury, no significant threat to any identifiable federal policy or interest, and no showing of any major damage that would result if state law is applied, any federal interest in the outcome of the question "is far too speculative, far too remote a possibility to justify the application of federal law to transactions essentially of local concern", *Boyle, 487 U.S. at 523.*

Even where the Government may arguably have to pay more, such a fact does not justify the creation of a new body of federal common law, *Boyle, 487 U.S. at 521, 522 (in dissent).* Indeed, this Court has previously rejected "more money" arguments remarkably similar to the one made here, *see O'Melveny, 512 U.S. at 88; Kimbell Foods, 440 U.S. at 737-738; Yazell, 382 U.S. at 348.*

Without proof that the application of state law will directly and substantially affect the United States or its Treasury, this Court should not embark upon the creation of a new body of federal common law, particularly without a clear legislative mandate to do so.

IV. PRECEDENTS DO NOT REQUIRE THAT EMPIRE'S SUIT BE HEARD BY A FEDERAL COURT APPLYING FEDERAL LAW

In an attempt to persuade this Court that all disputes arising under the terms of its contract should be heard by a federal court applying federal law, the Petitioner relies on a long line of cases, all having as their genesis the landmark case of *Erie R. Co. v. Tompkins, 304 U.S. 64 (1938).* In construing the Judiciary Act of 1789, *28 U.S.C.A. 1652*, this Court in *Erie* announced the general principal that there is no federal general common law, and stated that "(e)xcept in matters governed by the Federal Constitution or by acts of Congress, the law to be applied in any case is the law of the state", *Erie, 304 U.S. at 78.*

Many significant decisions followed, including *Clearfield Trust Co. v. United States, 318 U.S. 363 (1943); United States v. Standard Oil Co., 332 U.S. 301 (1947); United States v. Yazell, 382 U.S. 341 (1966); United States v. Little Lake Misere Land Co., 412 U.S. 580 (1973); United States v. Kimbell Foods, 440 U.S. 715 (1979); and O'Melveny & Myers v. F.D.I.C., 512 U.S. 79 (1994).*

What is striking when first looking at all of these cases is that, unlike the instant action, the United States was itself either a plaintiff or a defendant, with its rights and obligations directly at stake. Beyond that significant distinction, and in further contradiction to the Petitioner's position, an analysis of these cases shows that, under the facts in this case, the wholesale judicial creation of a new federal rule of decision is unwarranted.

In *Clearfield Trust*, this Court distinguished *Erie*, stating that "The rights and duties of the United States on commercial paper which it issues are governed by federal rather than local law. When the United States disburses its funds or pays its debts, it is exercising a constitutional function or power", *Clearfield, 318 U.S. at 366.*

What this Court found in *Clearfield Trust* was that, while the application of state law at times was appropriate, it was "singularly inappropriate" under the demonstrated facts of that case, because the application of state law "would subject the rights and duties of the United States to *exceptional uncertainty*." *Id. at 367 (emphasis supplied).*

The same cannot be said about this case. In this case, the United States is not a plaintiff or a defendant and there is no showing that the application of state law to this reimbursement claim would have any appreciable effect on the U.S. Treasury. Certainly, it is not shown in this case that the application of any state law would subject the rights and duties of the United States to "exceptional uncertainty".

Petitioner's unsubstantiated claim that there is "considerable variation in subrogation law across the country" has no application to the "reimbursement" claim in this case and, in any event, none of those subrogation laws have been cited. Nor is it demonstrated how the application of any state laws, whether they be subrogation laws or laws relating to reimbursement claims, would subject the rights and duties of the United States to any uncertainty, much less "exceptional uncertainty". Indeed, in this particular case, the Petitioner has failed to allege how New York law would even decide this case.

Contrary to ~~the~~ Petitioner's argument, the *Clearfield Trust* decision does not require this Court to judicially fashion, or apply, a new body of federal law to this case, but instead weighs heavily toward the application of existing state law.

The decision in *Standard Oil* is even more detrimental to the Petitioner's argument. In *Standard Oil*, this Court was called upon to decide, as a case of first impression, whether the United

States should be reimbursed by a third-party tortfeasor for medical costs incurred by an injured soldier.

At first glance, the *Standard Oil* decision appears to support the Petitioner's argument, in that this Court followed the rule enunciated in *Clearfield Trust*, rather than that of *Erie*, finding that the relations between soldiers and others were "fundamentally derived from federal sources and governed by federal authority", *Standard Oil, 332 U.S. at 305*. However, unlike the instant action, *Standard Oil* involved a subrogation claim against a third-party tortfeasor and not a reimbursement claim against its own federal employee, and, here again, the United States was itself the plaintiff.

Furthermore, even after finding, in *Standard Oil,* that federal law should generally govern the rights of soldiers, this Court still refrained from supplementing state law with a judicially created new body of federal common law, instead finding that the role of determining and establishing federal fiscal and regulatory policies was for congressional action, not for this Court or any other federal court. *Id at 314.*

> "...(Congress) is the primary and most often the exclusive arbiter of federal fiscal affairs. And these comprehend, as we have said, securing the treasury or the government against financial losses however inflicted, including requiring reimbursement for injuries creating them, as well as filling the treasury itself." *Id at 314-315.*
>
> "When Congress has thought it necessary to take steps to prevent interference with federal funds ... it has taken positive action to that end. We think it would have done so here, if that had been its

> desire. This it still may do, if or when it so wishes." *Id at 315-316.*
>
> "In view of these considerations, exercise of judicial power to establish the new liability not only would be intruding within a field properly within Congress' control and as to a matter concerning which it has seen fit to take no action." *Id at 316.*
>
> "The only question is which organ of the Government is to make the determination ... for the reasons we have stated, is in this instance for the Congress, not for the courts." *Id at 317.*

The decision in *Standard Oil* is diametrically opposed to the position taken by the Petitioner. The role of determining and establishing federal fiscal and regulatory policies, including any regulations providing for the recovery of medical costs incurred by a federal employee as the result of the negligence of a third-party, through subrogation or reimbursement, is with the Congress, not the federal courts.

To do otherwise would be intruding on a field properly within the control of Congress as to a matter concerning which it has seen fit to take no action. If in fact the reimbursement claim in this case is "fundamentally derived from federal sources and governed by federal authority" and directly affects the operation of this health benefit program or the U.S. Treasury (which it arguably does not), it is the Congress, as the "custodian of the national purse", *id at 314*, that should determine and establish the proper federal fiscal and regulatory policies, not this Court or other federal courts.

Almost 20 years after *Standard Oil*, this Court, in *Yazell*, was again faced with the continuing problem of the interaction of federal and state laws. Using *Clearfield Trust* as its base, the federal government in *Yazell* sought to collect money due on a loan.

Even with a specific showing of a state law that conflicted with a federal interest, unlike the present action, the government was still rebuffed by the trial and appellate courts.

In *Yazell*, this Court recognized that there is always a federal interest in collecting money which the government is owed and that its desire to collect was understandable, finding however, that the United States cannot, by judicial fiat, collect its money with total disregard of state laws. "Accordingly, generalities as to the paramountcy of the federal interest do not lead inevitably to the result the Government seeks", *Yazell, 382 U.S. at 348-349.*

In *Yazell*, this Court found that state law "should be overridden by the federal courts *only* where (the) *clear and substantial interests* of the National Government, which cannot be served consistently with respect for such state interests, will suffer *major damage* if the state law is applied." *Id at 352 (emphasis supplied).*

Here again, this decision does not support the Petitioner's claim. In this case, as in *Yazell*, there is no showing of any "major damage" to any "clear and substantial interests" of the U.S. Government. As such, neither the federal government, nor the Petitioner (or any other contract provider), should be permitted, "by judicial fiat" to collect their money with total disregard for state laws.

In *Little Lake Misere*, this Court again confronted the issue of whether it was appropriate to apply settled state law, or to fashion a new body of federal common law, into an area initially found to be of federal concern.

This Court found that "the answer to be given necessarily is dependent upon a variety of considerations always relevant to the nature of the specific governmental interest and to the effects upon them of applying state law", emphasizing that *settled state rules should be applied unless those rules "effect a discrimination against the government, or patently run counter to the terms of the Act", Little Lake Misere, 412 U.S. at 595-596, citing to RFC v. Beaver County, 328 U.S. 204 at 210 (emphasis supplied).*

Here again, the Petitioner's argument is not supported by the decision in *Little Lake Misere*. Under the specific facts in that case, this Court found that state law would abrogate the explicit terms of the federal statute and deal a serious blow to the congressional scheme, *Little Lake Misere, 412 U.S. at 597.*

There is no such showing in this case. Unlike the facts in *Little Lake Misere*, there is no showing here that the application of any state law would abrogate the explicit terms of the federal statute or deal a serious blow to the congressional scheme. Nor is it shown that any state law would "effect a discrimination against the government, or patently run counter to the terms of the Act".

In *Kimbell Foods*, as in this case, the government argued that the administration of a federal program required uniform federal rules. While this Court, citing to *Clearfield Trust*, acknowledged that general rule, it emphasized that even where a dispute is shown to directly affect the operation of a federal

program (which the Petitioner has not shown in this case), such a significant showing, in and of itself, does not "inevitably require resort to uniform federal rules", *Kimbell, 440 U.S. at 729, citing to Clearfield Trust and Little Lake Misere.*

In *Kimbell*, this Court was unpersuaded by the government's argument that nationwide standards were necessary to ease program administration or to safeguard the Federal Treasury and declined to override state laws of general applicability. As in this case, there was simply not a sufficient showing that state law would produce any significant hardship on the administration of the federal program.

Lastly, in *O'Melveny*, in a unanimous opinion delivered by Justice Scalia, this Court again concluded that without a significant conflict between some federal policy and the application of state law "this is not one of those extraordinary cases in which the judicial creation of a federal rule of decision was warranted", *O'Melveny, 512 U.S. at 88-89.* "Not only the permissibility but also the scope of judicial displacement of state rules turns upon such a conflict". *Id at 87-88.*

In a concurring opinion delivered by Justice Stevens, joined by Justice Blackmun, Justice O'Connor and Justice Souter, it was aptly stated that the federal courts, unlike their state counterparts, are courts of limited jurisdiction that have not been vested with open-ended lawmaking powers. "Unless Congress has otherwise directed, the federal court's task is merely to interpret and apply the relevant rules of state law." *Id at 90.*

Counter to the Petitioner's claims, the precedents set by this Court do not require that Empire's suit be heard by a federal court applying federal law. To the contrary, without a showing

that state law would inflict major damage to a clear and substantial interest of the federal government, these claims should be heard in state court applying state law, unless and until the Congress, as arbiter of federal fiscal affairs, establishes a federal fiscal policy and regulations to determine such claims.

V. PUBLIC POLICY CONSIDERATIONS

Where Congress has not offered conclusive guidance on an issue, it is entirely proper for this Court to consider, in addition to the factors already discussed, what may be described as policy considerations, *Blue Chip Stamps v. Manor Drug Stores, 421 U.S. 723, 737.* In this regard, the Respondent urges this Court to consider the relative benefits and detriments involved in expanding federal jurisdiction under FEHBA to include litigation of reimbursement claims in federal court.

The only argued benefit to extending Federal jurisdiction to include reimbursement claims is that (1) it will ensure uniformity in the administration of these claims among the several states, and (2) it will financially benefit the U.S. Treasury.

As previously argued, uniformity, in and of itself, is insufficient to justify displacing state law. Furthermore, there is no evidence presented to show that the adjudication of these reimbursement claims in the state courts will result in any divergent results.

In this case in particular, there is no showing that any New York law or regulation would, in any way, affect this health benefit plan or the Petitioner's claimed right of reimbursement. There is simply no allegation as to how any law, including New York law, would affect this case.

Regarding the Petitioner's argument that adjudication of these reimbursement claims in the federal courts will financially benefit the U. S. Treasury, no evidence of any kind has been presented to demonstrate that the application of any state laws, and particularly New York laws, would result in any appreciable losses to the U.S. Treasury. No financial statistics are provided, indeed, the Petitioner has not even alleged how many of these type of reimbursement claims even exist, or are paid or disputed each year. There is simply nothing to show any financial benefit, or detriment, to the U.S. Treasury by application of either state or federal law or jurisdiction.

Conversely, policy considerations dictate that reimbursement claims of private health insurers are best litigated in state court in the related personal injury action.

The logic employed by the Petitioner and the U.S. government would permit multiple plan administrators to include provisions in their various benefit plan documents, such as the Statement of Benefits in this case, that would authorize the reimbursement of medical expenses paid on the behalf of a federal employee out of that federal employee's personal injury settlement, arguably without regard for what the settlement payments were actually intended to compensate. Indeed, the Petitioner not only asserts a "right of reimbursement", it has claimed a contractual and/or equitable "lien" against the settlement proceeds.

Not only would adoption of such logic allow multiple plan administrators to make these claims and assert "liens" in federal court, these plan administrators would then be able to argue that the terms of their plans were "federal law", in total disregard of any state laws meant to protect their own employees.

Such a result would have devastating consequences to their own injured federal employees, not only by requiring them to reimburse such expenses out of their own recoveries, without regard to any state laws enacted for their benefit, but also by requiring them to litigate these claims in separately commenced federal actions at their own expense.

It would be in the best interests of the persons the statute was meant to benefit, namely federal employees, to allow reimbursement claims to be decided in the various state courts where their personal injury lawsuits are pending, where those reimbursement claims can be resolved quickly and inexpensively, rather than to subject those federal employees to the unnecessary costs, in time and money, of responding to actions independently commenced in the federal courts. To require a federal employee, as a personal injury plaintiff (or, in this case, his Estate) to engage in separate and prolonged litigation in the federal courts would be too burdensome, as well as unnecessary.

Not only would it benefit the federal employee for these reimbursement claims to be decided quickly and inexpensively in state court, it would also benefit the U.S. Treasury and the Petitioner as well, who would not have to incur the protracted legal expenses, filing fees and other incidental expenses associated with the commencement and prosecution of a separate federal action.

To expand federal jurisdiction to include litigation of these reimbursement claims in federal court would encourage costly and unnecessary litigation, to the benefit of no one and to the detriment of those federal employees the statute was enacted to protect.

The foremost example of the effects of the logic propounded by the Petitioner is demonstrated by the facts of this case.

In this case, the Petitioner was offered the opportunity, indeed encouraged, to resolve its reimbursement claim over three (3) years ago in open court, by way of a simple motion, made within the context of the Respondent's pending personal injury case. *See Hearing Transcript in Finn v. Town of Southampton, J.A., Vol. 1, 35-36.*

If the Petitioner had elected to resolve this case in that way, as it was encouraged to do, the attorney's fees and expenses incurred by all parties would likely have been a fraction of the fees and expenses incurred in this separately commenced federal action. Indeed, the cost in the New York courts to file the simple motion needed to resolve this claim would have been $45.00 and the claim would likely have been resolved in a few months, not years.

By electing to pursue this case in the federal court, the Petitioner has subjected the Estate of this deceased federal employee (and hence his widow and son) to the imposition of substantial, and unnecessary, legal fees and expenses.

Alternatively, the Petitioner could have elected to present this reimbursement claim to the New York State Surrogate's Court as a simple estate claim. Here again, the savings, in terms of both time and money, to not only the Estate of this deceased federal employee, but to the Petitioner and the federal government, would have been substantial.

It is not plausible that Congress meant for simple reimbursement claims to be resolved in the way propounded by

the Petitioner. Nor is it plausible that Congress intended to channel these simple reimbursement claims into the already overburdened federal courts.

To the contrary, it appears that Congress, by limiting federal jurisdiction to claims "against the United States" and by limiting preemption to claims involving "coverage or benefits", intentionally elected to keep these extraneous reimbursement claims, not related to "coverage or benefits", outside the federal courts and in the state courts where they belong.

Considering the relative benefits of keeping these types of extraneous claims in state court, and the detriments to doing otherwise, there is simply no compelling reason why the jurisdictional and preemptive reach of FEHBA should be extended by this Court.

CONCLUSION

In its narrowest terms, a decision in this case involves, simply, a question of proof; whether the Petitioner met its burden of establishing, in this case, sufficient evidence to show:

(1) a manifest intent on the part of Congress to extend federal court jurisdiction and preemption beyond the express language of the statute, or

(2) a direct and significant conflict between the application of state law and a federal policy or objective, or

(3) that the application of state law will, in any manner or to any appreciable extent, affect this health benefit plan or the U.S. Treasury.

The Respondent believes that the Petitioner has failed to present sufficient evidence to make any of these showings and that, as such, the decision of the Court of Appeals should be affirmed.

In its broadest sense, the issue in this case is whether a private contractor has the right, or the power under the Supremacy Clause, to make the terms of its health insurance contract, entered into pursuant to a federal statute but written by that private contractor, the "supreme Law of the Land", thereby preempting state laws, where those contract terms are tangential at most to the objective of the statute.

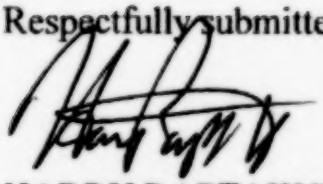
Certainly, the Petitioner and other contract providers should not be allowed, in their discretion, to implement any contract terms they desire and then, by judicial fiat, enforce those terms because they are "federal law" with a total disregard for state laws and for the interests of their own beneficiaries.

Under the test enunciated by this Court in *Boyle*, the health coverage and benefits provided to federal employees by FEHBA are protected from any unfavorable intrusion of state laws or regulations. That was the purpose of FEHBA's preemption provision and its purpose is served.

If Congress, as "the primary and most often exclusive arbiter of federal fiscal affairs", wishes to regulate and determine reimbursement rights as an exclusively federal matter and as a matter of federal fiscal policy, it may do so, if and when it so desires.

The decision of the Court of Appeals should be affirmed.

Respectfully submitted,



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IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.,
doing business as Empire Blue Cross Blue Shield,
Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER

INTRODUCTION

In our opening brief, we showed – in unison with the United States' position in its *amicus curiae* brief – that federal jurisdiction exists over Empire's complaint on at least two different bases. First, under cases such as *Jackson Transit Auth. v. Local Div. 1285, Amalgamated Transit Union, AFL-CIO-CLC*, 457 U.S. 15, 23 (1982), a suit for breach of a contract that is contemplated in a federal statute raises a federal claim where Congress intended the contract to be a "creature[ ] of federal law." Here, Empire's suit seeks to enforce the terms of a contract expressly set forth in FEHBA, and all indicia of Congress's intent signal that FEHBA contractual obligations are "federal in nature." *Id.* Second, this case involves the litigation of important programmatic interests of the federal government; as a result, under the framework first established in *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943), Empire's case is exclusively governed by federal common law and subject to federal jurisdiction.

Respondent refuses even to acknowledge this legal framework. Nowhere does Respondent (or, for that matter, her *amicus curiae*, Julia Cruz) so much as mention *Jackson Transit* or the similar decisions holding that suits to enforce contracts contemplated by federal statutes may raise federal claims. Nor does Respondent address the *Clearfield Trust* rule that matters concerning national federal programs are controlled by federal common law. On the latter point, instead of focusing on the nature of the FEHBA program and the federal interests in it, Respondent asks the Court to search for a specific conflict between the operation of state law and federal policy before adopting federal common law. That inquiry is unnecessary, but in any event here results in the displacement of state law.

What Respondent does address are the provisions in FEHBA permitting suits against the United States and expressly pre-empting state law, seeking to show that they do not apply by their terms to this case. Insofar as those arguments bear on jurisdiction under either *Jackson Transit* or *Clearfield Trust*, Respondent's arguments are illogical and unpersuasive. In the end, Respondent provides no support whatsoever for the odd conclusion that Congress intended state law and state courts to control the reimbursement of federally subsidized health benefits for the federal government's own workforce.

ARGUMENT

I. BECAUSE CONGRESS INTENDED THAT SUITS FOR BREACH OF FEHBA CONTRACTS WOULD RAISE FEDERAL CLAIMS, EMPIRE'S COMPLAINT POSES A FEDERAL QUESTION

A. Section 8912 Evinces a Congressional Intent to Treat FEHBA Contract Claims as Federal Claims

The central question under *Jackson Transit* and similar cases is whether Congress intended a claim for breach of the contract that is contemplated by a federal statute to be a federal claim or, alternatively, a state claim. Respondent focuses first and foremost on 5 U.S.C. § 8912, the provision in FEHBA that states: "The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter."

In essence, Respondent argues that § 8912 must be read as a statement by Congress not just that suits against the United States should be brought in the federal courts, but also that federal jurisdiction is prohibited over every other possible lawsuit stemming from FEHBA. Under Respondent's theory, the prohibition would have to extend to contract claims that Congress surely expected would be actionable somewhere. *See Jackson Transit*, 457 U.S. at 20 ("it is reasonable to conclude

that Congress expected the . . . agreement, like ordinary contracts, to be enforceable by private suit upon a breach").

Section 8912 cannot bear the weight Respondent places on it. Congress intended § 8912 simply to waive the sovereign immunity otherwise applicable for suits against the United States for monetary relief in the district courts. Under 28 U.S.C. § 1346(a)(2), a litigant can sue the United States in a district court for no more than $10,000; all suits above that amount against the United States must be brought in the Court of Federal Claims, formerly known as the Claims Court. Section 8912 expanded that jurisdiction, ensuring that lawsuits for amounts greater than $10,000 could be brought in convenient district court venues across the country, rather than solely in the Court of Federal Claims located in Washington, D.C.

The text of § 8912 substantiates this limited purpose for the provision. It speaks of district court jurisdiction "concurrent with the United States Court of Federal Claims," evincing on its face a desire to address jurisdictional matters affecting the latter court. Likewise, the legislative history supports this reading of § 8912. Section 8912 replicates verbatim a provision earlier enacted in the Federal Employees Group Life Insurance Act ("FEGLI"), 5 U.S.C. § 8715. With respect to that provision, Congress noted: "[The] Section . . . would clarify the rights of claimants who may wish to make the United States a party to a court action involving a claim under the program. This section would extend the jurisdiction of the United States district courts above the $10,000 limitation now in effect." S. Rep. No. 83-1654, at 4-5 (1954). Commenting on § 8912 in light of its FEGLI counterpart, the Claims Court itself remarked that both provisions were "enacted merely to enable making the United States a party to a court action in a district court, which would otherwise have been barred by the $10,000 limitation on suits against the United States in such court. 28 U.S.C. § 1346(b)." *Rosano v. United States*, 9 Cl. Ct. 137, 144 (1985), *aff'd*, 800 F.2d 1126 (Fed. Cir. 1986).

Indeed, if anything, § 8912 supports, not detracts from, federal jurisdiction over Empire's claim to enforce the FEHBA contract. As is evident from the text and history of § 8912, Congress enacted it in order to alter the *usual* jurisdictional rules that it expected would otherwise have governed district court jurisdiction (including, in particular, the $10,000 limitation in suits against the United States). The federal question jurisdiction that Empire invokes is another typical rule governing the federal courts' jurisdiction. It follows that, with Congress believing that the usual federal jurisdictional principles operate under FEHBA and therefore that express statutory change would be required to alter that usual framework (such as in enacting § 8912), Congress anticipated unfettered operation of the federal courts' federal question jurisdiction.

This Court's own precedent also negates Respondent's argument. In *Verizon Md., Inc. v. Public Serv. Comm'n*, 535 U.S. 635 (2002), the Court considered whether the federal courts had federal question jurisdiction over Verizon's suit alleging that a state utility commission's order violated federal communications laws and an order of the Federal Communications Commission. The lower courts rejected jurisdiction under 28 U.S.C. § 1331, and the state commission sought affirmance on the ground that Congress's grant of federal jurisdiction in 47 U.S.C. § 252(e)(6) to review certain determinations of state commissions precluded jurisdiction over other matters.

Rejecting the state commission's argument, the Court said that "Verizon's claim . . . falls within 28 U.S.C. § 1331's general grant of jurisdiction, and contrary to the Fourth Circuit's conclusion, nothing in 47 U.S.C. § 252(e)(6) purports to strip this jurisdiction." *Verizon*, 535 U.S. at 643. The section "merely makes *some other* actions by state commissions reviewable in federal court. This is not enough to eliminate jurisdiction under § 1331." *Id.* (emphasis in original). "'The mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others.'" *Id.* at

643-44 (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967)) (citation omitted). In *Verizon*, there was "nothing more than that mere fact," such as the creation of special review mechanisms or standards, to suggest that Congress wanted the jurisdiction that it did create to be exclusive. *Id.* at 644.

Just as in *Verizon*, the grant of jurisdiction over one category of claims in FEHBA (*i.e.*, actions against the United States) "does not *divest* the district courts of their authority under 28 U.S.C. § 1331 to review [other matters] for compliance with federal law." *Verizon*, 535 U.S. at 642 (emphasis in original). Nor does § 8912 create a "distinctive review mechanism" or speak to the available "substantive relief" (*id.* at 644). In fact, litigants invoking § 8912 jurisdiction in suing the United States must look to other statutes for their cause of action, such as the Administrative Procedure Act, 5 U.S.C. § 706.

Respondent cites this Court's decision in *Finley v. United States*, 490 U.S. 545 (1989), as somehow supportive of her construction of § 8912. It is not. In *Finley*, the Court rejected pendent-party jurisdiction in federal actions brought against the United States under the Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 1346(b). The FTCA prescribes that the district courts shall have "exclusive jurisdiction of civil actions on claims against the United States." 28 U.S.C. § 1346(b). All that the Court held was "that a grant of jurisdiction over claims involving particular parties does not *itself* confer jurisdiction over additional claims by or against different parties." 490 U.S. at 556 (emphasis added). Thus, Congress's allowance for suits against the United States would not permit "added claims involv[ing] added parties over whom no independent basis of jurisdiction exists." *Id.* at 551. Here, Empire is not invoking federal jurisdiction under § 8912; it agrees that that section permits jurisdiction over claims "against the United States and no one else." *Finley*, 490 U.S. at 552. Instead, Empire bases its claim on federal question jurisdiction, "an independent jurisdictional base." *Id.* at 547.

In sum, there is no basis in the text or history of § 8912 or in this Court's precedents for reading § 8912 as an iron-clad barrier to federal jurisdiction except in suits against the United States. Even the court of appeals below rejected Respondent's § 8912 argument. Pet. App. 14a n.7. This Court should do the same.

B. FEHBA's Preemption Provision Reinforces that Congress Expected Federal Law to Control Reimbursement Disputes

Respondent then addresses FEHBA's preemption provision, but none of her arguments shows even remotely that the section evidences any intent of Congress to make FEHBA contracts creatures of state law. As an initial matter, even if Respondent were correct that reimbursement matters do not fall within the scope of FEHBA's preemption clause, 5 U.S.C. § 8902(m)(1), that would not prove Congress intended state law to control the area of FEHBA reimbursement. The *Jackson Transit* inquiry is not coextensive with the preemption inquiry; rather, it asks whether Congress intended FEHBA contractual obligations to be federal in nature. That Congress was moved to enact a broad preemption provision in order expressly to limit the application of state law is a powerful indication that Congress saw state law as particularly ill-suited to matters touching on FEHBA, whether or not the preemption provision applies by its very terms to a particular controversy.

In any event, the preemption provision does cover reimbursement. Respondent and her *amicus* Julia Cruz assert that the preemption provision is inapplicable because the provision gives the "terms of [FEHBA] contract[s]" preemptive power , and the Statement of Benefits – the document containing the enrollee's reimbursement obligations – purportedly is not a contractual document. Instead, they say (each time without any record or other citation) that it is an instrument "Blue Cross prepared and issued to FEHBA plan enrollees." Br. for *Amicus*

Curiae Julia Cruz ("Cruz Br.") at 10; *see id.* at 20 n.9, 22, 25; Resp. Br. at 14, 39.

This unsupported assertion is belied by both the statute and the contract. FEHBA itself provides that "*[e]ach contract under this chapter shall contain* a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as *the Office* considers necessary or desirable." 5 U.S.C. § 8902(d) (emphasis added). This statutory provision alone shows that the Statement of Benefits is part of the contract and that OPM has final authority for benefits terms and exclusions. Consistent with the statutory requirement that it "shall contain a statement of benefits," the OPM-BCBSA contract specifically adopts and incorporates the Statement of Benefits and its reimbursement terms. *See* Pet. Br. at 17 (citing §§ 2.2 & 2.5 of the OPM-BCBSA contract). Additionally, given that the statute requires the Statement of Benefits to contain terms that "*the Office* considers necessary and desirable," the courts have correctly rejected the notion that the document is something that the carrier "author[s] and issue[s]" (Cruz Br. at 26) and instead have recognized that the "[b]enefits provisions are rules under the Administrative Procedure Act ["APA"], 5 U.S.C. § 551(4)." *Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 80 (4th Cir. 1993); *see also Doe v. Devine*, 703 F. 2d 1319, 1321, 1326 (D.C. Cir. 1983) (Ruth B. Ginsburg, J.) (applying APA's arbitrary-and-capricious test, which governs review of agency rules and adjudications, to a challenge to benefit levels set in the Service Benefit Plan's Statement of Benefits).

Amicus Cruz further argues that reimbursement terms are not part of the contract (and thus cannot preempt state law under § 8902(m)(1)) because the OPM-BCBSA contract addresses "subrogation" but is supposedly "silent on reimbursement." Cruz Br. at 20 n.9. First of all, because reimbursement indisputably is addressed in the Statement of Benefits, and because the Statement of Benefits is part of the contract, it is incorrect

to say that the OPM-BCBSA contract does not address reimbursement, even if the main contractual document were silent on it. But the OPM-BCBSA contract also expressly addresses reimbursement elsewhere. *See* J.A. 95 ("Subrogation" section states: "The carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer"); *id.* at 108, 125.[1]

Respondent next asserts that reimbursement falls outside of the preemption clause because the section allegedly "only provides for preemption when the issue involves 'coverage or benefits,' not for reimbursement claims." Resp. Br. at 9. Respondent then interprets "coverage or benefits" as encompassing only "benefits consisting of medical care." *Id.* Respondent crafts her argument by repeatedly omitting key statutory language. When quoting § 8902(m)(1), Respondent states that it "provides in pertinent part that the 'terms of any contract under this chapter *which relate to the nature, provision, or extent of coverage or benefits* . . . shall supersede and preempt any State or local law . . . .'" Resp. Br. at 8 (emphasis in Resp. Br.); *see also id.* at 4, 9, 12, 13, 18. The omitted parenthetical language clarifies that the term "benefits" encompasses "payments with respect to benefits," which plainly includes reimbursement payments, given that reimbursement is the return to the Plan of previous payments of benefits. 5 U.S.C. § 8902(m)(1); *see, e.g.*, *Blue Cross & Blue Shield of Ill. v. Cruz*, 396 F.3d 793, 798 (7th Cir. 2005) ("An enrollee's

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[1] The OPM-BCBSA contract contains two sections on subrogation. One is § 2.5 (J.A. 92, 118-19); the other is among the "Special Provisions" that relate to the Service Benefit Plan individually as opposed to being included necessarily in every FEHBA plan's contract. J.A. 95, 108, 125. In these various provisions, the contract uses "subrogation" broadly to include traditional subrogation (*i.e.*, the carrier stepping into the shoes of the enrollee to sue the third party) and reimbursement. This Court has similarly used the term "subrogation" broadly to encompass reimbursement. *See FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

reimbursement obligation after recovery from a third party affects the amount of net benefits received from the carrier, so it certainly satisfies the literal definition of being 'related to' the extent of coverage or benefits"), *petition for cert. pending*, No. 04-1657.

In a similar vein, *amicus* Cruz contends that reimbursement cannot involve benefits or coverage because "carrier coverage and benefit determinations, and payments with respect to those, are completed long before reimbursements are asserted and recovered." Cruz Br. at 11. The *amicus* overlooks the fact that benefits payments for injuries caused by third parties are, at the start, expressly *conditioned* on the enrollee's agreement to comply with the reimbursement provision. *See* J.A. 90, 92, 95, 165. Consequently, the benefit payment cannot be separated from the reimbursement obligation.

After seeking, unsuccessfully, to show that reimbursement falls outside of the literal terms of the preemption section, Respondent and the *amicus* try to prove that the legislative history to the original preemption section illustrates a Congressional desire to extend the preemption clause solely to state laws that mandate specific benefits. Resp. Br. at 13; Cruz Br. at 13-16. As we showed at length in our opening brief, the legislative record from the original preemption clause is rife with suggestions that Congress, with the wording it adopted, intended a broad preemption that would preserve only certain state licensing, reserve, and tax laws. Pet. Br. at 22, 26.[2]

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[2] *Amicus* Cruz argues that her crabbed view of the original preemption clause remains in force even today because the 1998 amendment effected just "technical" changes. Cruz Br. at 15. That assertion is contradicted both by Congress's statement that the amendment "broaden[ed]" the section (H.R. Rep. No. 105-374, at 9 (1997) (J.A. 24)) and by President Clinton's "objection," when he signed the 1998 amendment, to the "provision in this legislation that appears to expand preemption of State law remedies for FEHBP enrollees." Stmt. on Signing the Federal Employees Health Care Protection Act of 1998, 34 Weekly Comp. Pres. Doc. 2108 (Oct. 23, 1998).

C. Respondent's Analogies to Other Statutes Do Not Show a Congressional Intent in FEHBA Favoring State Law

Respondent reviews the language and case law surrounding several other federal statutes. One is the Federal Tort Claims Act, which we have already shown does not undermine federal jurisdiction over Empire's complaint. *See supra* p. 5. Another is ERISA. Respondent apparently believes that ERISA's reticulated enforcement scheme, with several vehicles for federal jurisdiction, suggests that Congress – not having created a similar enforcement scheme in FEHBA – expected federal jurisdiction over FEHBA matters to be strictly limited or nonexistent.

On this point, the ERISA analogy is inapt. When Congress enacted ERISA (14 years after FEHBA), it did so against the historical backdrop of the states having regulated private pensions and health benefits. *See Malone v. White Motor Corp.*, 435 U.S. 497, 507-14 (1978). Congress, accordingly, enacted a detailed enforcement scheme, since it was upending state law. In contrast, prior to FEHBA, there had been no program for health benefits for federal employees, and Congress logically had no similar necessity for comprehensively detailing the expected federal remedies. Indeed, since *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819), it had been the rule that the states may not impair the operations and instrumentalities of the federal government, so that Congress would have no reason whatsoever to contemplate that it had expressly to delineate applicable federal remedies in order to ensure that state law would not control an incident of federal operations, such as federal employment.

Respondent also cites the Civil Rights Act, 42 U.S.C. § 2000e-5(f)(3), and this Court's interpretation of it in *Yellow Freight Sys., Inc. v. Donnelly*, 494 U.S. 820 (1990), as contradicting the position that "Congress had intended for FEHBA

jurisdiction to be 'exclusive.'" Resp. Br. at 15. The argument is a red herring, because Empire has never asserted that the federal courts have exclusive jurisdiction over FEHBA reimbursement matters, only that it – as plaintiff – could elect to bring a reimbursement case in federal court under 28 U.S.C. § 1331. Similarly, it is of no relevance that Congress elsewhere may have provided by statute for reimbursement with respect to veterans' and social security benefits. *See* Resp. Br. at 13. Congress in FEHBA left to OPM the task of determining the specific benefits terms to be contained in FEHBA contracts, *see* 5 U.S.C. § 8902(d); *see also id.* § 8913 (delegating to OPM the authority to prescribe all necessary regulations to carry out FEHBA), and OPM has chosen to include a reimbursement obligation. That this obligation is contained in a contract contemplated in a federal statute (and can even be considered an agency rule, *see supra* p. 7), is sufficient – under *Jackson Transit* – for a federal claim.

II. EMPIRE'S COMPLAINT RAISES A FEDERAL CLAIM UNDER *CLEARFIELD TRUST* AND ITS PROGENY

Even aside from the *Jackson Transit* analysis, Empire's complaint also raises a federal claim under *Clearfield Trust* and its progeny. *Clearfield Trust* establishes a two-step framework for determining the role, if any, of state law in cases touching on national federal programs and government contracts – (1) whether the claim involves sufficiently weighty federal interests that federal common law should govern; and (2) whether that federal common law should provide an independent federal rule of decision or instead incorporate state law to some extent. As shown in our opening brief, because federal common law governs the area of FEHBA reimbursement, and because a claim founded on federal common law, in turn, raises a federal question, *Clearfield Trust* provides an additional, independent basis for the conclusion that Empire's complaint raises a federal claim. Pet. Br. at 32-44.

A. The First *Clearfield Trust* Inquiry Is Sufficient to Establish Federal Jurisdiction Here

The first *Clearfield Trust* inquiry goes directly to the question of federal jurisdiction. *See* Pet. Br. at 40-41. If Empire's claim arises under federal common law, then federal court jurisdiction exists under 28 U.S.C. § 1331, regardless of whether state law principles contribute to the content of that federal law. In providing for federal jurisdiction in a variety of circumstances, Congress has recognized that there are "advantages thought to be inherent in a federal forum" that should be available to litigants in appropriate circumstances. *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 125 S. Ct. 2363, 2367 (2005). Thus, it is a point of emphasis in many of the *Clearfield Trust* line of cases that "federal courts must fashion the governing rules." *Nat'l Metro. Bank v. United States*, 323 U.S. 454, 456 (1945); *see, e.g., United States v. Little Lake Misere Land Co.*, 412 U.S. 580, 593 (1973) (the claim involved "'a federal right, so that the courts of the United States may formulate a rule of decision'") (quoting Henry J. Friendly, *In Praise of Erie – And of the New Federal Common Law*, 39 N.Y.U. L. Rev. 383, 410 (1964)); *United States v. Standard Oil Co.*, 332 U.S. 301, 307, 310 (1947) (invoking the "federal judicial power to deal with . . . essentially federal matters" before determining that "state law should not be selected as the federal rule").

Respondent objects that there is no specific evidence that "state adjudication" will adversely affect the United States' interests here. Resp. Br. at 21. But a determination that federal jurisdiction is appropriate does not require any specific negative conclusions concerning state court jurisdiction. Rather, embedded in the *Clearfield Trust* approach is the recognition that factors such as the federal courts' "experience" with and "solicitude" for federal issues and federal programmatic interests (*Grable*, 125 S. Ct. at 2367) makes those courts the proper forum for resolving disputes that significantly affect those interests. *See Merrell Dow Pharms., Inc. v. Thompson*, 478

U.S. 804, 814 & n.12 (1986) (the "*nature* of the federal interest at stake" determines whether a case is "the kind of adjudication for which [federal] jurisdiction would serve congressional purposes and the federal system") (emphasis added).

As explained in our opening brief (at 38 n.3), in cases where the first *Clearfield Trust* inquiry "is of only theoretical interest" because federal jurisdiction exists in any event, the Court on occasion has addressed only the question whether the rule of decision displaces state law. *See O'Melveny & Myers v. FDIC*, 512 U.S. 79, 85 (1994); *Boyle v. United Techs. Corp.*, 487 U.S. 500, 508 n.3 (1988); *United States v. Yazell*, 382 U.S. 341, 357 (1966). Respondent relies heavily on these cases (*see* Resp. Br. 19-20, 31) and, perhaps for that reason, largely ignores the possibility that federal question jurisdiction could exist here without displacing state law. In other cases, however, the Court has made clear that it continues to adhere to the two-inquiry approach of *Clearfield Trust*. Hence, in *Kamen v. Kemper Fin. Servs.*, 500 U.S. 90 (1991), the Court found that the claim clearly was "governed by *federal* law," but held that the federal courts should incorporate state law into the federal common law rule of decision. *Id.* at 97-98 (emphasis added).

Because Empire's "activities '[arise] from and [bear] heavily upon a federal . . . program,'" its claim is governed by federal law and therefore falls within § 1331's federal question jurisdiction. *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 727 (1979) (quoting *Little Lake Misere*, 412 U.S. at 592-93) (alterations and ellipsis in *Kimbell Foods*). This federal jurisdiction would exist even if Respondent were correct that, as in *Kamen* and *Kimbell Foods*, state law generally should not be displaced as the rule of decision.

B. In Any Event, State Law Does Not Apply Under the Second *Clearfield Trust* Inquiry

There nevertheless is no place for state law here under the second *Clearfield Trust* inquiry. Congress has determined that uniform rules should govern benefits payments under FEHBA,

and incorporating the varied state law rules applicable to reimbursement actions would subvert that determination.

Respondent, echoing the court of appeals, contends that federal law cannot apply because Empire has not identified a specific conflict between state law and federal interests. *See* Resp. Br. 21-25. That contention fails both because there is no such conflict requirement applicable here and, in any case, there is a clear conflict between the application of state rules governing reimbursement and the FEHBA program's interest in uniform enforcement of contract provisions.

Respondent's requirement of a specific conflict purports to derive from language in *Boyle* and *O'Melveny*, where the Court signaled that federal common law will displace state rules when there is a "significant conflict" between the operation of state law and federal policy. *Boyle*, 487 U.S. at 507-08; *O'Melveny*, 512 U.S. at 87. As already noted (Pet. Br. at 41-43), the "significant conflict" language in these decisions did not profess to set forth a test for the application of federal common law when Congress has already expressly stated the need for uniformity in a federal program by including a pre-emption provision in the statute. *See O'Melveny*, 512 U.S. at 85 ("an explicit federal statutory provision" answers the question of displacement of state law); *Boyle*, 487 U.S. at 504 (state law is displaced when there is "a clear statutory prescription" for "federal pre-emption of state law"). Similarly, in *Atherton v. FDIC*, 519 U.S. 213 (1997), the Court discussed the need for a "significant conflict" only after assuming that the statute did not suggest displacement of state law. *Id.* at 218; *see id.* at 217 ("setting the federal 'gross negligence' statute to the side"). In sharp contrast to this case, the relevant statute there contained a "saving clause that . . . preserves the applicability of stricter state standards." *Id.* at 227. Here, the statute contains a pre-emption clause explicitly displacing state law – one that Congress amended to remove language conditioning preemption on a conflict with state law. *See* Pet. Br. at 24, 41-42.

Likewise, this case does not involve a "generalized plea[ ] for uniformity" of the sort previously rejected by the Court in cases finding that the federal interest was equally served by having state law rules apply. *See O'Melveny*, 512 U.S. at 88; *Kimbell Foods*, 440 U.S. at 730. Those cases do not question that a genuine need for uniformity is grounds for application of federal common law; they merely recognize that "[t]o invoke the concept of 'uniformity,' however, is not to prove its need." *Atherton*, 519 U.S. at 220. But Congress, in FEHBA, specifically determined that there is a need for uniformity. FEHBA provides that all contract terms relating to "payments with respect to benefits" shall preempt state law (5 U.S.C. § 8902(m)(1)), and the legislative history identifies the desire for FEHBA plans to offer "uniform benefits" nationwide as the reason for the preemption clause. H.R. Rep. No. 105-374, at 9 (1997) (J.A. 24); *see also* S. Rep. No. 95-903, at 2 (1978) (Congress sought "to establish uniformity in benefits"). Following from Congress's direction, the OPM-BCBSA contract requires that the carrier "shall subrogate under a single, nationwide policy to ensure equitable and consistent treatment for all Members." J.A. 95, 103, 125.

Congress's documented desire for uniformity is at risk in this case. State laws vary widely with respect to regulation of reimbursement actions like the one involved here. Some states would prohibit such actions altogether, while others would impose no special obstacles to enforcement of a contractual reimbursement provision. *See* Patricia G. Tobin, *The Rawlings & Assocs. National Subrogation Law Manual 1998*, at 51-53 (1997).[3] Thus, there would be a serious conflict with the FE-

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[3] Arizona, Connecticut, Kansas, Missouri, North Carolina, Pennsylvania, and Virginia generally prohibit enforcement of reimbursement clauses concerning medical expenses. *See* Tobin, *supra*, at 89-90, 111-12, 171-72, 229-30, 279-81, 309-11, 353-54. New York generally allows subrogation and reimbursement. *Id.* at 274-75.

HBA program if state law generally were to govern these actions (even if there were no New York state law rule that would prevent enforcement of the FEHBA government contract in this case). Enrollees in some jurisdictions (those where reimbursement is prohibited or limited) would receive higher net benefits payments than enrollees in other jurisdictions (those where reimbursement is unhampered), despite paying the same premium, thereby destroying the uniformity in benefits that Congress sought to ensure. In short, even if a specific conflict with federal interests were required for the application of a federal rule of decision, that requirement is satisfied in the context of a suit to enforce the reimbursement clause of a FEHBA contract.

C. It Makes No Difference That the United States Is Not a Party to the Action

Respondent suggests that the *Clearfield Trust* line of decisions is inapposite because, in those cases, "the United States was itself either a plaintiff or a defendant, with its rights and obligations directly at stake." Resp. Br. 27. But the presence of the United States as a party to the litigation is not a prerequisite to the application of federal common law. *See Boyle*, 487 U.S. at 504, 511-13 (applying federal common law defense in suit between private parties); *Nat'l Farmers Union Ins. Cos. v. Crow Tribe of Indians*, 471 U.S. 845, 850-53 (1985) (power of Indian tribe); *Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972) (nuisance action). Similarly, in *Little Lake Misere*, 412 U.S. at 592-94, the Court focused on the regulatory program and the status of the United States as a party *to the contract* at issue, but its status as a party to the lawsuit played no role in the Court's reasoning. Denomination of the United States as a party should particularly be of no moment in a case like this, where a private entity (*i.e.*, Empire) brings the suit on behalf of the government and the relief inures to the government's, not the private party's, benefit. *See* Pet. Br. at 39.

Also instructive on this point are the decisions of the courts of appeals consistently recognizing that private-party suits to enforce flood insurance contracts are governed by federal law and heard in federal court based on federal question jurisdiction. *E.g.*, *Battle v. Seibels Bruce Ins. Co.*, 288 F.3d 596, 607 (4th Cir. 2002) ("federal common law *alone* governs the interpretation of insurance policies issued pursuant to the [flood insurance program]") (emphasis added); *Downey v. State Farm Fire & Cas. Co.*, 266 F.3d 675, 681-82 (7th Cir. 2001) (§ 1331 jurisdiction exists when "the federal interest in a controversy is so dominant that federal law applies . . . – even if the national government is not a party"); *Newton v. Capital Assur. Co.*, 245 F.3d 1306, 1309 (11th Cir. 2001) (flood insurance "contracts are interpreted using principles of federal common law rather than state contract law"). As Judge Easterbrook explained for the Seventh Circuit, "[t]ypically the United States is a party to disputes that call for federal law under the approach of *Clearfield Trust*. But there is no reason to view that condition as a necessity," especially if "a judgment against [the private party] and a judgment against [the government] have identical effects: [the government] pays." *Downey*, 266 F.3d at 681. The principle should be the same here, given that – regardless of whether Empire or the United States is the plaintiff – the government gains from the relief.

III. THERE ARE NO PUBLIC POLICY ADVANTAGES TO EXCLUSIVE STATE COURT JURISDICTION IN THIS SETTING

Respondent expends much energy extolling the advantages of exclusive state court jurisdiction over FEHBA reimbursement. Resp. Br. at 34-38. That effort is misguided. Insofar as the Court delves into policy considerations, they all favor strongly federal question jurisdiction.

For instance, Respondent erroneously maintains that reimbursement can quickly and efficiently be determined in the state courts in conjunction with the underlying tort suit against

the third party. However, given the many anti-subrogation laws prevalent under state law, resort to the state courts will likely devolve in many cases into disputes over the extent of the operation of state law. Tellingly, in this case, where the proceedings had not progressed beyond the earliest stages, Respondent had already invoked a New York statute of limitations designed to limit subrogation. *See* 2d Cir. App. A824. The prospect is that FEHBA carriers, if left to the state courts, will face heavy litigation burdens in order to enforce plan terms.

The ready availability of federal jurisdiction, in contrast, *expedites* reimbursement. The potential of a federal lawsuit, where the contract terms and other federal law straightforwardly control, would deter enrollees seeking to avoid reimbursement obligations. As a result, litigation might never even materialize in the first place. The exact opposite dynamic would exist if there were exclusively state court jurisdiction: enrollees would be empowered to seek to avoid the contract terms through the application of potentially hostile state law.

Moreover, as the *Cruz* litigation (part of which is pending on petition for certiorari currently in this Court (No. 04-1657)) shows, only a federal forum can guarantee that all of the necessary parties will be present in some reimbursement disputes. Cruz has pending in the state court in Illinois a suit in which she endeavors to avoid her full reimbursement obligation by applying Illinois law to require an automatic, pro-rata reduction for attorney fees she incurred to obtain the third-party recovery. Application of Illinois' automatic-reduction rule would negate the Service Benefit Plan's terms, which permit no reductions unless the carrier in its discretion approves them. J.A. 132, 153. Cruz's effort to nullify the Plan's terms implicates OPM's interests, since it is responsible for selecting the Plan's provisions. In refusing to abstain from exercising jurisdiction in the companion case in the federal courts (now pending here) in favor of the state court action, the Seventh Circuit said:

> The state court action will not adequately protect Blue Cross's and Blue Cross Association's interests, in part because Cruz's state court action seeks to declare illegal the Service Benefit Plan terms regarding subrogation that OPM promulgated. OPM would be unable to participate as a party in a state court suit under 5 U.S.C. § 8912. Resolving the case in federal court would eliminate this potential problem because it would allow OPM to participate in the event that Cruz raises the legality of the contract subrogation provision.

Blue Cross & Blue Shield of Ill. , Inc. v. Cruz, 396 F.3d 793, 801 (7th Cir. 2005), *petition for cert. pending*, No. 04-1657. In every case in state court in which the enrollee seeks to override the Plan's terms with state law, sovereign immunity principles would prevent the real party in interest – the United States – from being present. *Dugan v. Rank*, 372 U.S. 609, 620 (1963) ("The general rule is that a suit is against the sovereign if the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration . . . or if the effect of the judgment would be to restrain the Government from acting, or to compel it to act.") (citations omitted).

Finally, Respondent contends that federal jurisdiction would harm "the persons the statute was meant to benefit, namely federal employees." Resp. Br. at 36. That contention is mistaken on two grounds. First, the statute was not intended just to protect federal employees and certainly not particularly to protect individual employees obtaining tort recoveries; it was also designed to promote *the government's* interest in attracting the most capable workforce at the lowest possible cost to the government. *See* Br. for the U.S. as *Amicus Curiae* at 16; *Doe v. Devine*, 703 F.2d 1319, 1329 (D.C. Cir. 1983). That interest is furthered by facilitating enforcement of contract provisions that would keep premium costs down. Second, federal employees as a whole benefit from a straightforward federal remedy and forum that provides uniform benefits for all enrol-

lees and avoids costly state court litigation that drains Plan resources. And there are many checks in the system designed to protect federal employees from any arbitrary or unfair conduct in the reimbursement context. For instance, the enrollee, in the federal action, can raise any defenses that the contract terms would permit. Furthermore, OPM retains full authority to police carrier conduct. *See* 5 U.S.C. § 8902(e) (OPM's authority over carrier conduct); *id.* § 8910 (OPM's audit authority); 2d Cir. App. A23 (OPM's procedures to assure quality assurance); 48 C.F.R. §§ 1609.7001, 1646.201 (same); *see generally Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 350-52 (2001) (state law remedy preempted by FDA's policing authority).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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APRIL 2006

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

EMPIRE HEALTHCHOICE ASSURANCE, INC. DBA EMPIRE BLUE CROSS BLUE SHIELD *v.* McVEIGH AS ADMINISTRATRIX OF THE ESTATE OF McVEIGH

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

No. 05–200. Argued April 25, 2006—Decided June 15, 2006

Under the Federal Employees Health Benefits Act of 1959 (FEHBA), the Office of Personnel Management (OPM) negotiates and regulates health-benefits plans for federal employees. See 5 U. S. C. §8902(a). FEHBA provides for Government payment of about 75% of health-plan premiums, and for enrollee payment of the rest. §8906(b). Premiums thus shared are deposited in a special Treasury Fund, from which carriers draw to pay for covered benefits. §8909(a). FEHBA has a preemption provision which provides: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law . . . which relates to health insurance or plans." §8902(m)(1). The Act contains no provision addressing carriers' subrogation or reimbursement rights. FEHBA's sole jurisdictional provision vests federal district courts with "original jurisdiction . . . of a civil action or claim against the United States." §8912. While an OPM regulation channels disputes over coverage or benefits into federal court by designating OPM the sole defendant, see 5 CFR §890.107(c), no law opens federal courts to carriers seeking reimbursement.

OPM has contracted with the Blue Cross Blue Shield Association (BCBSA) to provide a nationwide fee-for-service health plan administered by local companies (Plan). The Plan obligates the carrier to make "a reasonable effort" to recoup amounts paid for medical care, and the statement of benefits the carrier distributes alerts enrollees that recoveries they receive must be used to reimburse the Plan for benefits paid. Petitioner Empire HealthChoice Assurance, Inc. (Em-

Syllabus

pire), administers the BCBSA Plan as it applies to federal employees in New York State. Respondent Denise McVeigh (McVeigh) is the administrator of the estate of Joseph McVeigh (Decedent), a former Plan enrollee who was injured in an accident. This case originated when a state-court tort suit brought by McVeigh against third parties alleged to have caused the Decedent's injuries terminated in a settlement. Empire filed this suit in federal court invoking 28 U. S. C. §1331, which authorizes jurisdiction over "civil actions arising under the . . . laws . . . of the United States." Empire sought reimbursement of the $157,309 it had paid under the Plan for the Decedent's medical care, with no offset for McVeigh's attorney's fees or other litigation costs in the state-court tort action. The District Court granted McVeigh's motion to dismiss for want of subject-matter jurisdiction.

The Second Circuit affirmed, holding that Empire's claim arose under state law. Observing that FEHBA's text does not authorize carriers to vindicate in federal court their rights against enrollees under FEHBA-authorized contracts, the court concluded that federal jurisdiction could exist only if federal common law governed Empire's claim. Quoting *Boyle* v. *United Technologies Corp.*, 487 U. S. 500, 507, 508, the appeals court stated that courts may create federal common law only when state law would (1) "'significant[ly] conflict'" with (2) "'uniquely federal interest[s].'" Empire maintained that its contract-derived reimbursement claim implicated "uniquely federal interest[s]" because (1) reimbursement directly affects the United States Treasury and the cost of providing health benefits to federal employees, and (2) Congress has expressed its interest in maintaining uniformity among the States on matters relating to federal health-plan benefits. The court acknowledged that the case involved such interests, but found that Empire had not identified specific ways in which the operation of state law would conflict materially with the policies underlying FEHBA in the circumstances presented. Also rejecting Empire's argument that FEHBA's preemption provision independently conferred federal jurisdiction, the court emphasized that §8902(m)(1) makes no reference to a federal right of action in, or federal jurisdiction over, a contract-derived reimbursement claim.

Held: Section 1331 does not encompass Empire's suit. Pp. 9–21.

(a) A case "aris[es] under federal law" for §1331 purposes if "a well-pleaded complaint establishes either that federal law creates the cause of action or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." *Franchise Tax Bd. of Cal.* v. *Construction Laborers Vacation Trust for Southern Cal.*, 463 U. S. 1, 27–28. Pp. 9–10.

(b) *Clearfield Trust Co.* v. *United States*, 318 U. S. 363, does not provide a basis for federal jurisdiction here. In *Clearfield*, a Govern-

ment suit against a bank to recover the amount paid on a Government check on which the payee's name had been forged, *id.*, at 365, the Court held that "[t]he rights and duties of the United States on commercial paper which it issues are governed by federal rather than [state] law." *id.*, at 366. In post-*Clearfield* decisions, however, the Court made clear that uniform federal law need not always be applied in Government litigation. For example, in *United States* v. *Kimbell Foods, Inc.*, 440 U. S. 715, 740, the Court declared that "the prudent course" is often "to adopt the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation." The reimbursement and subrogation provisions in the OPM-BCBSA contract are linked together and depend upon a recovery from a third party under terms and conditions ordinarily governed by state law. Focusing on reimbursement, the appeals court determined that Empire has not demonstrated a significant conflict between an identifiable federal interest and the operation of state law. Unless and until that showing is made, there is no cause to displace state law, much less to lodge this case in federal court. Pp. 10–12.

(c) Empire and *amicus* United States argue that, under *Jackson Transit Authority* v. *Transit Union*, 457 U. S. 15, 22, Empire's reimbursement claim, arising under the OPM-BCBSA contract, states a federal claim because Congress intended all rights and duties stemming from that contract to be federal in nature.

The reliance placed on *Jackson Transit* is surprising, for the Court there determined that the claim at issue—a union's suit against a city agency to enforce agreements the parties had made in light of §13(c) of the Urban Mass Transportation Act of 1964 (UMTA), which conditioned the city's receipt of federal funds on preservation of employees' collective-bargaining rights—did not arise under federal law, but was instead "governed by state law [to be] applied in state cour[t]." *Id.*, at 29. The Court there acknowledged prior decisions "determin[ing] that a plaintiff stated a federal claim when he sued to vindicate contractual rights *set forth by federal statutes* [that] lacked express provisions creating federal causes of action." *Id.*, at 22 (emphasis added). However, the Court held that these cases did not control because "the critical factor" in each of them was "the congressional intent behind the particular provision at issue." *Ibid.* Although there were some indications that the UMTA made "§13(c) agreements and collective-bargaining contracts creatures of federal law," *id.*, at 23, countervailing considerations—primarily a long-standing National Labor Relations Act exemption for labor relations between local governments and their employees—demonstrated a congressional intent to the contrary, *id.*, at 23–24.

Measured against *Jackson Transit*'s discussion of when a claim

arises under federal law, Empire's contract-derived reimbursement claim is not a "creatur[e] of federal law." *Id.*, at 23. While distinctly federal elements are involved here, countervailing considerations control, particularly FEHBA's jurisdictional provision, §8912, which opens the federal district-court door to civil actions "against the United States." OPM's regulation, 5 CFR §809.107(c), instructs enrollees seeking to challenge benefit denials to proceed in federal court against OPM "and not against the carrier or carrier's subcontractors." Read together, these prescriptions ensure that beneficiaries' suits will land in federal court. Had Congress found it necessary or proper to extend federal jurisdiction to contract-derived reimbursement claims between carriers and insured workers, it would have been easy enough to say so. Cf. 29 U. S. C. §1132(a)(3). *Jackson Transit* noted that while "private parties in appropriate cases may sue in federal court to enforce contractual rights created by federal statutes," 457 U. S., at 22, *Jackson Transit* involved no such right.

Nor can §8902(m)(1), FEHBA's preemption prescription, be read as a jurisdiction-conferring provision. That prescription is unusual in that it renders preemptive contract terms in health insurance plans, not provisions enacted by Congress. A prescription of that unusual order warrants cautious interpretation. Section 8902(m)(1) is a puzzling measure, open to more than one construction, and no prior decision seems to us precisely on point. If §8902(m)(1) does not cover contract-based reimbursement claims, then federal jurisdiction clearly does not exist. But even if §8902(m)(1) reaches such claims, the prescription is not sufficiently broad to confer federal jurisdiction. If Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear. Cf., *e.g.*, *Columbus* v. *Ours Garage & Wrecker Service, Inc.*, 536 U. S. 424, 432–433. Congress has not done so here. Section 8902(m)(1) does not purport to render inoperative *any and all* state laws that in some way bear on federal employee-benefit plans. Cf. 29 U. S. C. §1144(a). And, given that §8902(m)(1) declares no federal law preemptive, but instead, terms of an OPM-BCBSA negotiated contract, a modest reading of the provision is in order. Furthermore, a reimbursement right of the kind Empire here asserts stems from a personal-injury recovery, and the claim underlying that recovery is plainly governed by state law. This Court is not prepared to say, based on the presentations made in this case, that under §8902(m)(1), an OPM-BCBSA contract term would displace every condition state law places on that recovery. The BCBSA Plan's statement of benefits links together the carrier's right to reimbursement from the insured and its right to subrogation. Empire's subrogation right allows it, once it has paid an

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insured's medical expenses, to recover directly from a third party responsible for the insured's injury or illness. Had Empire taken that course, no access to a federal forum could have been predicated on the OPM-BCBSA contract right. The tortfeasors' liability, whether to the insured or the insurer, would be governed not by an agreement to which the tortfeasors are strangers, but by state law, and §8902(m)(1) would have no sway. Pp. 12–18.

(d) Also rejected is the United States' alternative argument that Empire's reimbursement claim arises under federal law for §1331 purposes because federal law is a necessary element of the carrier's claim for relief. In making this argument, the Government relies on *Grable & Sons Metal Products, Inc.* v. *Darue Engineering & Mfg.*, 545 U. S. 308, which involved real property owned by Grable that the Internal Revenue Service (IRS) seized to satisfy a federal tax deficiency, *id.*, at 310. Grable received notice of the seizure by certified mail before the IRS sold the property to Darue. Grable later sued Darue in state court to quiet title, asserting that Darue's record title was invalid because the IRS had conveyed the seizure notice improperly under 26 U. S. C. §6335(a), which requires that "notice in writing . . . be given . . . to the owner . . . or . . . left at his usual place of abode or business." Darue removed the case to federal court. Alleging that Grable's title depended on the interpretation of a federal statute, §6335(a), Darue invoked federal-question jurisdiction under 28 U. S. C. §1331. This Court held that the removal was proper because §6335(a)'s meaning was an important federal-law issue that sensibly belonged in a federal court, and the question whether Grable received adequate notice was "the only . . . issue contested in the case." 545 U. S., at 315. This case is poles apart from *Grable*. Here, the reimbursement claim was triggered, not by a federal agency's action, but by the settlement of a personal-injury action launched in state court, and the bottom-line practical issue is the share of that settlement properly payable to Empire. *Grable* presented a nearly pure issue of law, the resolution of which would establish a rule applicable to numerous tax sale cases. Empire's reimbursement claim, in contrast, is fact bound and situation specific. Although the United States is correct that a reimbursement claim may also involve as an issue the extent to which the reimbursement should take account of attorney's fees expended to obtain the tort recovery, it is hardly apparent why a proper federal-state balance would place such a nonstatutory issue under the complete governance of federal law, to be declared in a federal forum. The state court in which the personal-injury suit was lodged is competent to apply federal law, to the extent it is relevant, and would seem best positioned to determine the lawyer's part in obtaining, and fair share in, the tort recovery. The Government's im-

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portant interests in attracting able workers and assuring their health and welfare do not warrant turning into a discrete and costly "federal case" an insurer's contract-derived claim to be reimbursed from a federal worker's state-court-initiated tort litigation. This case cannot be squeezed into the slim category *Grable* exemplifies. Pp. 18–21.

396 F. 3d 136, affirmed.

GINSBURG, J., delivered the opinion of the Court, in which ROBERTS, C. J., and STEVENS, SCALIA, and THOMAS, JJ., joined. BREYER, J., filed a dissenting opinion, in which KENNEDY, SOUTER, and ALITO, JJ., joined.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 05–200

EMPIRE HEALTHCHOICE ASSURANCE, INC., DBA EMPIRE BLUE CROSS BLUE SHIELD, PETITIONER *v.* DENISE F. McVEIGH, AS ADMINISTRATRIX OF THE ESTATE OF JOSEPH E. McVEIGH

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

[June 15, 2006]

JUSTICE GINSBURG delivered the opinion of the Court.

The Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U. S. C. §8901 *et seq.* (2000 ed. and Supp. III), establishes a comprehensive program of health insurance for federal employees. The Act authorizes the Office of Personnel Management (OPM) to contract with private carriers to offer federal employees an array of health-care plans. See §8902(a) (2000 ed.). Largest of the plans for which OPM has contracted, annually since 1960, is the Blue Cross Blue Shield Service Benefit Plan (Plan), administered by local Blue Cross Blue Shield companies. This case concerns the proper forum for reimbursement claims when a plan beneficiary, injured in an accident, whose medical bills have been paid by the plan administrator, recovers damages (unaided by the carrier-administrator) in a state-court tort action against a third party alleged to have caused the accident.

FEHBA contains a preemption clause, §8902(m)(1), displacing state law on issues relating to "coverage or

benefits" afforded by health-care plans. The Act contains no provision addressing the subrogation or reimbursement rights of carriers. Successive annual contracts between OPM and the Blue Cross Blue Shield Association (BCBSA) have obligated the carrier to make "a reasonable effort" to recoup amounts paid for medical care. App. 95, 125. The statement of benefits distributed by the carrier alerts enrollees that all recoveries they receive "must be used to reimburse the Plan for benefits paid." *Id.*, at 132; see also *id.*, at 146, 152.

The instant case originated when the administrator of a Plan beneficiary's estate pursued tort litigation in state court against parties alleged to have caused the beneficiary's injuries. The carrier had notice of the state-court action, but took no part in it. When the tort action terminated in a settlement, the carrier filed suit in federal court seeking reimbursement of the full amount it had paid for the beneficiary's medical care. The question presented is whether 28 U. S. C. §1331 (authorizing jurisdiction over "civil actions arising under the . . . laws . . . of the United States") encompasses the carrier's action. We hold it does not.

FEHBA itself provides for federal-court jurisdiction only in actions against the United States. Congress could decide and provide that reimbursement claims of the kind here involved warrant the exercise of federal-court jurisdiction. But claims of this genre, seeking recovery from the proceeds of state-court litigation, are the sort ordinarily resolved in state courts. Federal courts should await a clear signal from Congress before treating such auxiliary claims as "arising under" the laws of the United States.

I

FEHBA assigns to OPM responsibility for negotiating and regulating health benefits plans for federal employees. See 5 U. S. C. §8902(a). OPM contracts with carriers,

FEHBA instructs, "shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." §8902(d). Pursuant to FEHBA, OPM entered into a contract in 1960 with the BCBSA to establish a nationwide fee-for-service health plan, the terms of which are renegotiated annually. As FEHBA prescribes, the Federal Government pays about 75% of the premiums; the enrollee pays the rest. §8906(b) (2000 ed.). Premiums thus shared are deposited in a special Treasury Fund, the Federal Employees Health Benefits Fund, §8909(a). Carriers draw against the Fund to pay for covered health-care benefits. *Ibid.*; see also 48 CFR §1632.170(b) (2005).

The contract between OPM and the BCBSA provides: "By enrolling or accepting services under this contract, [enrollees and their eligible dependents] are obligated to all terms, conditions, and provisions of this contract." App. 90. An appended brochure sets out the benefits the carrier shall provide, see *id.*, at 89, and the carrier's subrogation and recovery rights, see *id.*, at 100. Each enrollee, as FEHBA directs, receives a statement of benefits conveying information about the Plan's coverage and conditions. 5 U. S. C. §8907(b). Concerning reimbursement and subrogation, matters FEHBA itself does not address, the BCBSA Plan's statement of benefits reads in part:

> "If another person or entity . . . causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:
>
> "All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees."

. . . . .

> "If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
>
> "If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover." App. 165.[1]

If the participant does not voluntarily reimburse the Plan, the contract requires the carrier to make a "reasonable effort to seek recovery of amounts . . . it is entitled to recover in cases . . . brought to its attention." *Id.*, at 95, 125. Pursuant to the OPM-BCBSA master contract, reimbursements obtained by the carrier must be returned to the Treasury Fund. See *id.*, at 92, 118–119.

FEHBA contains a preemption provision, which originally provided:

> "The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law

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[1]The statement of benefits further provides:

"You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

"We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

"*Note:* We will pay the costs of any covered services you receive that are in excess of any recoveries made." App. 165.

> or regulation is inconsistent with such contractual provisions." 5 U. S. C. §8902(m)(1) (1994 ed.).

To assure uniform coverage and benefits under plans OPM negotiates for federal employees, see H. R. Rep. No. 95–282, p. 1 (1977), §8902(m)(1) preempted "State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage," *id.*, at 4–5 (noting that some States mandated coverage for services not included in federal plans, for example, chiropractic services). In 1998, Congress amended §8902(m)(1) by deleting the words "to the extent that such law or regulation is inconsistent with such contractual provisions." Thus, under §8902(m)(1) as it now reads, state law—whether consistent or inconsistent with federal plan provisions—is displaced on matters of "coverage or benefits."

FEHBA contains but one provision addressed to federal-court jurisdiction. That provision vests in federal district courts "original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter." §8912. The purpose of this provision—evident from its reference to the Court of Federal Claims—was to carve out an exception to the statutory rule that claims brought against the United States and exceeding $10,000 must originate in the Court of Federal Claims. See 28 U. S. C. §1346(a)(2) (establishing district courts' jurisdiction, concurrent with the Court of Federal Claims, over claims against the United States that do not exceed $10,000); see also S. Rep. No. 1654, 83d Cong., 2d Sess., pp. 4–5 (1954) (commenting, with respect to an identical provision in the Federal Employees Group Life Insurance Act, 5 U. S. C. §8715, that the provision "would extend the jurisdiction of United States district courts above the $10,000 limitation now in

effect").

Under a 1995 OPM regulation, suits contesting final OPM action denying health benefits "must be brought against OPM and not against the carrier or carrier's subcontractors." 5 CFR §890.107(c) (2005). While this regulation channels disputes over coverage or benefits into federal court by designating a United States agency (OPM) sole defendant, no law opens federal courts to carriers seeking reimbursement from beneficiaries or recovery from tortfeasors. Cf. 29 U. S. C. §1132(e)(1) (provision of the Employee Retirement Income Security Act (ERISA) vesting in federal district courts "exclusive jurisdiction of civil actions under this subchapter"). And nothing in FEHBA's text prescribes a federal rule of decision for a carrier's claim against its insured or an alleged tortfeasor to share in the proceeds of a state-court tort action.

II

Petitioner Empire Healthchoice Assurance, Inc., doing business as Empire Blue Cross Blue Shield (Empire), is the entity that administers the BCBSA Plan as it applies to federal employees in New York State. Respondent Denise Finn McVeigh (McVeigh) is the administrator of the estate of Joseph E. McVeigh (Decedent), a former enrollee in the Plan. The Decedent was injured in an accident in 1997. Plan payments for the medical care he received between 1997 and his death in 2001 amounted to $157,309. McVeigh, on behalf of herself, the Decedent, and a minor child, commenced tort litigation in state court against parties alleged to have caused Decedent's injuries. On learning that the parties to the state-court litigation had agreed to settle the tort claims, Empire sought to recover the $157,309 it had paid out for the Decedent's medical care.[2] Of the $3,175,000 for which the settlement

[2]At oral argument, counsel for respondent McVeigh represented that "most of the [reimbursement claims] are not of th[is] magnitude";

provided, McVeigh, in response to Empire's asserted reimbursement right, agreed to place $100,000 in escrow.

Empire then filed suit in the United States District Court for the Southern District of New York, alleging that McVeigh was in breach of the reimbursement provision of the Plan. As relief, Empire demanded $157,309, with no offset for attorney's fees or other litigation costs McVeigh incurred in pursuing the state-court settlement. McVeigh moved to dismiss on various grounds, among them, lack of subject-matter jurisdiction. See 396 F. 3d 136, 139 (CA2 2005). Answering McVeigh's motion, Empire urged that the District Court had jurisdiction under 28 U. S. C. §1331 because federal common law governed its reimbursement claim. In the alternative, Empire asserted that the Plan itself constituted federal law. See 396 F. 3d, at 140. The District Court rejected both arguments and granted McVeigh's motion to dismiss for want of subject-matter jurisdiction. *Ibid.*

A divided panel of the Court of Appeals for the Second Circuit affirmed, holding that "Empire's clai[m] arise[s] under state law." *Id.*, at 150. FEHBA's text, the court observed, contains no authorization for carriers "to vindicate [in federal court] their rights [against enrollees] under FEHBA-authorized contracts"; therefore, the court concluded, "federal jurisdiction exists over this dispute only if federal common law governs Empire's claims." *Id.*, at 140. Quoting *Boyle* v. *United Technologies Corp.*, 487 U. S. 500, 507, 508 (1988), the appeals court stated that courts may create federal common law only when "the operation of state law would (1) 'significant[ly] conflict' with (2) 'uniquely federal interest[s].'" 396 F. 3d, at 140.

Empire maintained that its contract-derived claim against McVeigh implicated "uniquely federal interest[s]."

"[m]ost of the cases involve [amounts like] $5,500 and $6,500." Tr. of Oral Arg. 52.

because (1) reimbursement directly affects the United States Treasury and the cost of providing health benefits to federal employees; and (2) Congress had expressed its interest in maintaining uniformity among the States on matters relating to federal health-plan benefits. *Id.*, at 141. The court acknowledged that the case involved distinctly federal interests, but found that Empire had not identified "specific ways in which the operation of state contract law, or indeed of other laws of general application, would conflict materially with the federal policies underlying FEHBA in the circumstances presented." *Id.*, at 150 (Sack, J., concurring); see *id.*, at 142.

The Court of Appeals next considered and rejected Empire's argument that FEHBA's preemption provision, 5 U. S. C. §8902(m)(1), independently conferred federal jurisdiction. 396 F. 3d, at 145–149. That provision, the court observed, is "a limited preemption clause that the instant dispute does not trigger." *Id.*, at 145. Unlike §8912, which "authoriz[es] federal jurisdiction over FEHBA-related . . . claims '*against the United States*,'" the court noted, §8902(m)(1) "makes no reference to a federal right of action [in] or to federal jurisdiction [over]" the contract-derived reimbursement claim here at issue. 396 F. 3d, at 145, and n. 7.

Judge Raggi dissented. *Id.*, at 151. In her view, FEHBA's preemption provision, §8902(m)(1), as amended in 1998, both calls for the application of uniform federal common law to terms in a FEHBA plan and establishes federal jurisdiction over Empire's complaint.

We granted certiorari, 546 U. S. ___ (2005), to resolve a conflict among lower federal courts concerning the proper forum for claims of the kind Empire asserts. Compare *Blue Cross & Blue Shield of Illinois* v. *Cruz*, 396 F. 3d 793, 799–800 (CA7 2005) (upholding federal jurisdiction), *Caudill* v. *Blue Cross & Blue Shield of North Carolina*, 999 F. 2d 74, 77 (CA4 1993) (same), and *Medcenters Health*

Care v. *Ochs*, 854 F. Supp. 589, 593, and n. 3 (Minn. 1993) (same), aff'd, 26 F. 3d 865 (CA8 1994), with *Goepel* v. *Nat. Postal Mail Handlers Union*, 36 F. 3d 306, 314–315 (CA3 1994) (rejecting federal jurisdiction), and 396 F. 3d, at 139 (decision below) (same).

III

Title 28 U. S. C. §1331 vests in federal district courts "original jurisdiction" over "all civil actions arising under the Constitution, laws, or treaties of the United States." A case "aris[es] under" federal law within the meaning of §1331, this Court has said, if "a well-pleaded complaint establishes either that federal law creates the cause of action or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." *Franchise Tax Bd. of Cal.* v. *Construction Laborers Vacation Trust for Southern Cal.*, 463 U. S. 1, 27–28 (1983).

Empire and the United States, as *amicus curiae*, present two principal arguments in support of federal-question jurisdiction. Emphasizing our opinion in *Jackson Transit Authority* v. *Transit Union*, 457 U. S. 15, 22 (1982), and cases cited therein, they urge that Empire's complaint raises a federal claim because it seeks to vindicate a contractual right contemplated by a federal statute, a right that Congress intended to be federal in nature. See Brief for Petitioner 14–31; Brief for United States 12–23. FEHBA's preemption provision, Empire and the United States contend, demonstrates Congress' intent in this regard. The United States argues, alternatively, that there is federal jurisdiction here, as demonstrated by our recent decision in *Grable & Sons Metal Products, Inc.* v. *Darue Engineering & Mfg.*, 545 U. S. 308 (2005), because "federal law is a necessary element of [Empire's] claim." Brief for United States 25; accord Brief for Petitioner 41, n. 5. We address these arguments in turn. But first, we

respond to the dissent's view that Empire and the United States have engaged in unnecessary labor, for *Clearfield Trust Co.* v. *United States*, 318 U. S. 363 (1943), provides "a basis for federal jurisdiction in this case." *Post*, at 1.

A

Clearfield is indeed a pathmarking precedent on the authority of federal courts to fashion uniform federal common law on issues of national concern. See Friendly, In Praise of *Erie*—and of the New Federal Common Law, 39 N. Y. U. L. Rev. 383, 409–410 (1964). But the dissent is mistaken in supposing that the *Clearfield* doctrine covers this case. *Clearfield* was a suit by the United States to recover from a bank the amount paid on a Government check on which the payee's name had been forged. 318 U. S., at 365. Because the United States was the plaintiff, federal-court jurisdiction was solidly grounded. See *ibid.* ("This suit was instituted . . . by the United States . . . , the jurisdiction of the federal District Court being invoked pursuant to the provisions of §24(1) of the Judicial Code, 28 U. S. C. §41(1)," now contained in 28 U. S. C. §§1332, 1345, 1359). The case presented a vertical choice-of-law issue: Did state law under *Erie R. Co.* v. *Tompkins*, 304 U. S. 64 (1938), or a court-fashioned federal rule of decision (federal common law) determine the merits of the controversy? The Court held that "[t]he rights and duties of the United States on commercial paper which it issues are governed by federal rather than [state] law." 318 U. S., at 366.

In post-*Clearfield* decisions, and with the benefit of enlightened commentary, see, *e.g.*, Friendly, *supra*, at 410, the Court has "made clear that uniform federal law need not be applied to all questions in federal government litigation, even in cases involving government contracts," R. Fallon, D. Meltzer, & D. Shapiro, Hart and Wechsler's The Federal Courts and the Federal System 700 (5th ed. 2003)

(hereinafter Hart and Wechsler).[3] "[T]he prudent course," we have recognized, is often "to adopt the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation." *United States* v. *Kimbell Foods, Inc.*, 440 U. S. 715, 740 (1979).

Later, in *Boyle*, the Court telescoped the appropriate inquiry, focusing it on the straightforward question whether the relevant federal interest warrants displacement of state law. See 487 U. S., at 507, n. 3. Referring simply to "the displacement of state law," the Court recognized that prior cases had treated discretely (1) the competence of federal courts to formulate a federal rule of decision, and (2) the appropriateness of declaring a federal rule rather than borrowing, incorporating, or adopting state law in point. The Court preferred "the more modest terminology," questioning whether "the distinction between displacement of state law and displacement of federal law's incorporation of state law ever makes a practical difference." *Ibid.* *Boyle* made two further observations here significant. First, *Boyle* explained, the involvement of "an area of uniquely federal interest . . . establishes a necessary, not a sufficient, condition for the displacement of state law." *Id.*, at 507. Second, in some cases, an "entire body of state law" may conflict with the federal interest and therefore require replacement. *Id.*, at 508. But in others, the conflict is confined, and "only

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[3]The United States, in accord with the dissent in this regard, see *post*, at 6, several times cites *United States* v. *County of Allegheny*, 322 U. S. 174 (1944), see, *e.g.*, Brief as *Amicus Curiae* 10, 15, 26, maintaining that the construction of a federal contract "necessarily present[s] questions of 'federal law not controlled by the law of any State.'" *id.*, at 26 (quoting 322 U. S., at 183). *Allegheny* does not stretch as widely as the United States suggests. That case concerned whether certain property belonged to the United States and, if so, whether the incidence of a state tax was on the United States or on a Government contractor. See *id.*, at 181–183, 186–189. Neither the United States nor any United States agency is a party to this case, and the auxiliary matter here involved scarcely resembles the controversy in *Allegheny*.

particular elements of state law are superseded." *Ibid.*

The dissent describes this case as pervasively federal, *post*, at 1, and "the provisions . . . here [as] just a few scattered islands in a sea of federal contractual provisions," *post*, at 9. But there is nothing "scattered" about the provisions on reimbursement and subrogation in the OPM-BCBSA master contract. See *supra*, at 3–4. Those provisions are linked together and depend upon a recovery from a third party under terms and conditions ordinarily governed by state law. See *infra*, at 17.[4] The Court of Appeals, whose decision we review, trained on the matter of reimbursement, not, as the dissent does, on FEHBA-authorized contracts at large. So focused, the appeals court determined that Empire has not demonstrated a "significant conflict . . . between an identifiable federal policy or interest and the operation of state law." 396 F. 3d, at 150 (Sack, J., concurring), quoting *Boyle*, 487 U. S., at 507)); see 396 F. 3d, at 140–141. Unless and until that showing is made, there is no cause to displace state law, much less to lodge this case in federal court.

B

We take up next Empire's *Jackson Transit*-derived argument, which is, essentially, a more tailored variation of the theme sounded in the dissent. It is undisputed that Congress has not expressly created a federal right of action enabling insurance carriers like Empire to sue health-care beneficiaries in federal court to enforce reimbursement rights under contracts contemplated by FEHBA. Empire and the United States nevertheless argue that, under our 1982 opinion in *Jackson Transit*, Empire's claim for reimbursement, arising under the contract between OPM and BCBSA, "states a federal claim" because Congress in-

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[4]The dissent nowhere suggests that uniform, court-declared federal law would govern the carrier's subrogation claim against the tortfeasor. Nor does the dissent explain why the two linked provisions—reimbursement and subrogation—should be decoupled.

tended all rights and duties stemming from that contract to be "federal in nature." Brief for United States as *Amicus Curiae* 12; see Brief for Petitioner 18–29. We are not persuaded by this argument.

The reliance placed by Empire and the United States on *Jackson Transit* is surprising, for that decision held there was no federal jurisdiction over the claim in suit. The federal statute there involved, §13(c) of the Urban Mass Transportation Act of 1964 (UMTA), 78 Stat. 307 (then codified at 49 U. S. C. §1609(c) (1976 ed.)), conditioned a governmental unit's receipt of federal funds to acquire a privately owned transit company on preservation of collective-bargaining rights enjoyed by the acquired company's employees. 457 U. S., at 17–18. The city of Jackson, Tennessee, with federal financial assistance, acquired a failing private bus company and turned it into a public entity, the Jackson Transit Authority. *Id.*, at 18. To satisfy the condition on federal aid, the transit authority entered into a "§13(c) agreement" with the union that represented the private company's employees, and the Secretary of Labor certified that agreement as "fair and equitable." *Ibid.* (internal quotation marks omitted).

For several years thereafter, the transit authority covered its unionized workers in a series of collective-bargaining agreements. Eventually, however, the Authority notified the union that it would no longer adhere to collective-bargaining undertakings. *Id.*, at 19. The union commenced suit in federal court alleging breach of the §13(c) agreement and of the latest collective-bargaining agreement. *Ibid.* This Court determined that the case did not arise under federal law, but was instead "governed by state law [to be] applied in state cour[t]." *Id.*, at 29.

The Court acknowledged in *Jackson Transit* that "on several occasions [we had] determined that a plaintiff stated a federal claim when he sued to vindicate contractual rights *set forth by federal statutes*, [even though] the

relevant statutes lacked express provisions creating federal causes of action." *Id.*, at 22 (emphasis added) (citing *Machinists* v. *Central Airlines, Inc.*, 372 U. S. 682 (1963) (union had a federal right of action to enforce an airline-adjustment-board award included in a collective-bargaining contract pursuant to a provision of the Railway Labor Act); *Norfolk & Western R. Co.* v. *Nemitz*, 404 U. S. 37 (1971) (railroad's employees stated federal claims when they sought to enforce assurances made by the railroad to secure Interstate Commerce Commission approval of a consolidation under a provision of the Interstate Commerce Act); *Transamerica Mortgage Advisors, Inc.* v. *Lewis*, 444 U. S. 11, 18–19 (1979) (permitting federal suit for rescission of a contract declared void by a provision of the Investment Advisers Act of 1940)). But prior decisions, we said, "d[id] not dictate the result in [the *Jackson Transit*] case," for in each case, "the critical factor" in determining "the scope of rights and remedies under a federal statute . . . is the congressional intent behind the particular provision at issue." 457 U. S., at 22.

"In some ways," the *Jackson Transit* Court said, the UMTA "seem[ed] to make §13(c) agreements and collective-bargaining contracts creatures of federal law." *Id.*, at 23. In this regard, the Court noted, §13(c)

> "demand[ed] 'fair and equitable arrangements' as prerequisites for federal aid; it require[d] the approval of the Secretary of Labor for those arrangements; it specifie[d] five different varieties of protective provisions that must be included among the §13(c) arrangements; and it expressly incorporate[d] the protective arrangements into the grant contract between the recipient and the Federal Government." *Ibid.* (quoting 49 U. S. C. §1609(c) (1976 ed.)).

But there were countervailing considerations. The Court observed that "labor relations between local gov-

ernments and their employees are the subject of a long-standing statutory exemption from the National Labor Relations Act." 457 U. S., at 23. "Section 13(c)," the Court continued, "evince[d] no congressional intent to upset the decision in the [NLRA] to permit state law to govern the relationships between local governmental entities and the unions representing their employees." *Id.*, at 23–24. Legislative history was corroborative. "A consistent theme," the Court found, "[ran] throughout the consideration of §13(c): Congress intended that labor relations between transit workers and local governments would be controlled by state law." *Id.*, at 24. We therefore held that the union had come to the wrong forum. Congress had indeed provided for §13(c) agreements and collective-bargaining contracts stemming from them, but in the Court's judgment, the union's proper recourse for enforcement of those contracts was a suit in state court.

Measured against the Court's discussion in *Jackson Transit* about when a claim arises under federal law, Empire's contract-derived claim for reimbursement is not a "creatur[e] of federal law." *Id.*, at 23. True, distinctly federal interests are involved. Principally, reimbursements are credited to a federal fund, and the OPM-BCBSA master contract could be described as "federal in nature" because it is negotiated by a federal agency and concerns federal employees. See *supra*, at 2–3. But, as in *Jackson Transit*, countervailing considerations control. Among them, the reimbursement right in question, predicated on a FEHBA-authorized contract, is not a prescription of federal law. See *supra*, at 3. And, of prime importance, "Congress considered jurisdictional issues in enacting FEHBA[,]. . . confer[ring] federal jurisdiction where it found it necessary to do so." 396 F. 3d, at 145, n. 7.

FEHBA's jurisdictional provision, 5 U. S. C. §8912, opens the federal district-court door to civil actions "against the United States." See *supra*, at 5. OPM's regu-

lation, 5 CFR §890.107(c) (2005), instructs enrollees who seek to challenge benefit denials to proceed in court against OPM "and not against the carrier or carrier's subcontractors." See *supra*, at 6. Read together, these prescriptions "ensur[e] that suits brought by beneficiaries for denial of benefits will land in federal court." 396 F. 3d, at 145, n. 7. Had Congress found it necessary or proper to extend federal jurisdiction further, in particular, to encompass contract-derived reimbursement claims between carriers and insured workers, it would have been easy enough for Congress to say so. Cf. 29 U. S. C. §1132(a)(3) (authorizing suit in federal court "by a participant, beneficiary, or fiduciary" of a pension or health plan governed by ERISA to gain redress for violations of "this subchapter or the terms of the plan"). We have no warrant to expand Congress' jurisdictional grant "by judicial decree." See *Kokkonen* v. *Guardian Life Ins. Co. of America*, 511 U. S. 375, 377 (1994).

Jackson Transit, Empire points out, referred to decisions "demonstrat[ing] that . . . private parties in appropriate cases may sue in federal court to enforce contractual rights created by federal statutes." 457 U. S., at 22. See Brief for Petitioner 15. This case, however, involves no right created by federal statute. As just reiterated, while the OPM-BCBSA master contract provides for reimbursement, FEHBA's text itself contains no provision addressing the reimbursement or subrogation rights of carriers.

Nor do we read 5 U. S. C. §8902(m)(1), FEHBA's preemption prescription, see *supra*, at 4–5, as a jurisdiction-conferring provision. That choice-of-law prescription is unusual in that it renders preemptive contract terms in health insurance plans, not provisions enacted by Congress. See 396 F. 3d, at 143–145; *id.*, at 151 (Sack, J., concurring). A prescription of that unusual order warrants cautious interpretation.

Section 8902(m)(1) is a puzzling measure, open to more

than one construction, and no prior decision seems to us precisely on point. Reading the reimbursement clause in the master OPM-BCBSA contract as a condition or limitation on "benefits" received by a federal employee, the clause could be ranked among "[contract] terms . . . relat[ing] to . . . coverage or benefits" and "payments with respect to benefits," thus falling within §8902(m)(1)'s compass. See Brief for United States as *Amicus Curiae* 20; Reply Brief 8–9. On the other hand, a claim for reimbursement ordinarily arises long after "coverage" and "benefits" questions have been resolved, and corresponding "payments with respect to benefits" have been made to care providers or the insured. With that consideration in view, §8902(m)(1)'s words may be read to refer to contract terms relating to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he or she has received, and not to terms relating to the carrier's post-payments right to reimbursement. See Brief for Julia Cruz as *Amicus Curiae* 10, 11.

To decide this case, we need not choose between those plausible constructions. If contract-based reimbursement claims are not covered by FEHBA's preemption provision, then federal jurisdiction clearly does not exist. But even if FEHBA's preemption provision reaches contract-based reimbursement claims, that provision is not sufficiently broad to confer federal jurisdiction. If Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear. Cf. *Columbus* v. *Ours Garage & Wrecker Service, Inc.*, 536 U. S. 424, 432–433 (2002) (citing *Wisconsin Public Intervenor* v. *Mortier*, 501 U. S. 597, 605 (1991)). Congress has not done so here.

Section 8902(m)(1)'s text does not purport to render inoperative *any and all* State laws that in some way bear on federal employee-benefit plans. Cf. 29 U. S. C. §1144(a)

(portions of ERISA "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). And, as just observed, see *supra*, at 14, given that §8902(m)(1) declares no federal law preemptive, but instead, terms of an OPM-BCBSA negotiated contract, a modest reading of the provision is in order. Furthermore, a reimbursement right of the kind Empire here asserts stems from a personal-injury recovery, and the claim underlying that recovery is plainly governed by state law. We are not prepared to say, based on the presentations made in this case, that under §8902(m)(1), an OPM-BCBSA contract term would displace every condition state law places on that recovery.

As earlier observed, the BCBSA Plan's statement of benefits links together the carrier's right to reimbursement from the insured and its right to subrogation. See *supra*, at 3–4. Empire's subrogation right allows the carrier, once it has paid an insured's medical expenses, to recover directly from a third party responsible for the insured's injury or illness. See 16 G. Couch, Cyclopedia of Insurance Law §61:1 (2d ed. 1982). Had Empire taken that course, no access to a federal forum could have been predicated on the OPM-BCBSA contract right. The tortfeasors' liability, whether to the insured or the insurer, would be governed not by an agreement to which the tortfeasors are strangers, but by state law, and §8902(m)(1) would have no sway.

In sum, the presentations before us fail to establish that §8902(m)(1) leaves no room for any state law potentially bearing on federal employee-benefit plans in general, or carrier-reimbursement claims in particular. Accordingly, we extract from §8902(m)(1) no prescription for federal-court jurisdiction.

C

We turn finally to the argument that Empire's reim-

bursement claim, even if it does not qualify as a "cause of action created by federal law," nevertheless arises under federal law for §1331 purposes, because federal law is "a necessary element of the [carrier's] claim for relief." Brief for United States as *Amicus Curiae* 25–26 (quoting *Grable*, 545 U. S., at 312, and *Jones* v. *R. R. Donnelley & Sons Co.*, 541 U. S. 369, 376 (2004)). This case, we are satisfied, does not fit within the special and small category in which the United States would place it. We first describe *Grable*, a recent decision that the United States identifies as exemplary,[5] and then explain why this case does not resemble that one.

Grable involved real property belonging to Grable & Sons Metal Products, Inc. (Grable), which the Internal Revenue Service (IRS) seized to satisfy a federal tax deficiency. 545 U. S., at 310. Grable received notice of the seizure by certified mail before the IRS sold the property to Darue Engineering & Manufacturing (Darue). *Ibid.* Five years later, Grable sued Darue in state court to quiet title. Grable asserted that Darue's record title was invalid because the IRS had conveyed the seizure notice improperly. *Id.*, at 311. The governing statute, 26 U. S. C. §6335(a), provides that "notice in writing shall be given . . . to the owner of the property . . . or shall be left at his usual place of abode or business . . . ." Grable maintained that §6335(a) required personal service, not service by certified mail. 545 U. S., at 311.

Darue removed the case to federal court. Alleging that Grable's claim of title depended on the interpretation of a federal statutory provision, *i.e.*, §6335(a) of the Internal Revenue Code, Darue invoked federal-question jurisdiction under 28 U. S. C. §1331. We affirmed lower court deter-

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[5] As the Court in *Grable* observed, 545 U. S., at 312, the classic example of federal-question jurisdiction predicated on the centrality of a federal issue is *Smith* v. *Kansas City Title & Trust Co.*, 255 U. S. 180 (1921).

minations that the removal was proper. "The meaning of the federal tax provision," we said, "is an important issue of federal law that sensibly belongs in a federal court." 545 U. S., at 315. Whether Grable received notice adequate under §6335(a), we observed, was "an essential element of [Grable's] quiet title claim"; indeed, "it appear[ed] to be the only . . . issue contested in the case." *Ibid.*

This case is poles apart from *Grable*. Cf. Brief for United States as *Amicus Curiae* 27. The dispute there centered on the action of a federal agency (IRS) and its compatibility with a federal statute, the question qualified as "substantial," and its resolution was both dispositive of the case and would be controlling in numerous other cases. See *id.*, at 313. Here, the reimbursement claim was triggered, not by the action of any federal department, agency, or service, but by the settlement of a personal-injury action launched in state court, see *supra*, at 6–7, and the bottom-line practical issue is the share of that settlement properly payable to Empire.

Grable presented a nearly "pure issue of law," one "that could be settled once and for all and thereafter would govern numerous tax sale cases." Hart and Wechsler 65 (2005 Supp.). In contrast, Empire's reimbursement claim, McVeigh's counsel represented without contradiction, is fact-bound and situation-specific. McVeigh contends that there were overcharges or duplicative charges by care providers, and seeks to determine whether particular services were properly attributed to the injuries caused by the 1997 accident and not rendered for a reason unrelated to the accident. See Tr. of Oral Arg. 44, 53.

The United States observes that a claim for reimbursement may also involve as an issue "[the] extent, if any, to which the reimbursement should take account of attorney's fees expended . . . to obtain the tort recovery." Brief as *Amicus Curiae* 29. Indeed it may. But it is hardly

apparent why a proper "federal-state balance," see *id.*, at 28, would place such a nonstatutory issue under the complete governance of federal law, to be declared in a federal forum. The state court in which the personal-injury suit was lodged is competent to apply federal law, to the extent it is relevant, and would seem best positioned to determine the lawyer's part in obtaining, and his or her fair share in, the tort recovery.

The United States no doubt "has an overwhelming interest in attracting able workers to the federal workforce," and "in the health and welfare of the federal workers upon whom it relies to carry out its functions." *Id.*, at 10. But those interests, we are persuaded, do not warrant turning into a discrete and costly "federal case" an insurer's contract-derived claim to be reimbursed from the proceeds of a federal worker's state-court-initiated tort litigation.

In sum, *Grable* emphasized that it takes more than a federal element "to open the 'arising under' door." 545 U. S., at 313. This case cannot be squeezed into the slim category *Grable* exemplifies.

* * *

For the reasons stated, the judgment of the Court of Appeals for the Second Circuit is

Affirmed.

SUPREME COURT OF THE UNITED STATES

No. 05–200

EMPIRE HEALTHCHOICE ASSURANCE, INC., DBA EMPIRE BLUE CROSS BLUE SHIELD, PETITIONER *v.* DENISE F. McVEIGH, AS ADMINISTRATRIX OF THE ESTATE OF JOSEPH E. McVEIGH

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

[June 15, 2006]

JUSTICE BREYER, with whom JUSTICE KENNEDY, JUSTICE SOUTER, and JUSTICE ALITO join, dissenting.

This case involves a dispute about the meaning of terms in a federal health insurance contract. The contract, between a federal agency and a private carrier, sets forth the details of a federal health insurance program created by federal statute and covering 8 million federal employees. In all this the Court cannot find a basis for federal jurisdiction. I believe I can. See *Clearfield Trust Co.* v. *United States*, 318 U. S. 363 (1943).

I

A

There is little about this case that is not federal. The comprehensive federal health insurance program at issue is created by a federal statute, the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U. S. C. §8901 *et seq* (2000 ed. and Supp. III). This program provides insurance for Federal Government employees and their families. That insurance program today covers approximately 8 million federal employees, retirees, and dependents, at a total cost to the Government of about $22 billion a year. Brief for United States as *Amicus Curiae* 2.

To implement the statute, the Office of Personal Management (OPM), the relevant federal agency, enters into contracts with a handful of major insurance carriers. These agency/carrier contracts follow a standard agency form of about 38,000 words, and contain the details of the plan offered by the carrier. See §8902(d) (2000 ed.) (requiring contract between carrier and agency to contain a detailed statement of the terms of the plan); see also Federal Employees Health Benefits Program Standard Contract (CR–2003) (2005), available at http://www.opm.gov/insure/carriers/sample contract.doc (sample form agency/carrier contract) (all Internet materials as visited June 7, 2006, and available in Clerk of Court's case file). The contract lists, for example, the benefits provided to the employees who enroll. It provides a patient's bill of rights. It makes clear that the Government, not the carrier, will receive the premiums and will pay the benefits. It specifies that the carrier will administer the program that the contract sets forth, for which the carrier will receive an adjustable fee. The contract also states, "By enrolling or accepting services under this contract, [enrollees] are obligated to all terms, conditions, and provisions of this contract." App. 90.

As the statute requires, §8907(b), the agency/carrier contract also provides that the carrier will send each enrolled employee a brochure that explains the terms of the plan, as set forth in the contract. The brochure explains that it "describes the benefits of the . . . [p]lan under [the carrier's] contract . . . with [the federal agency], as authorized by the [federal statute]." *Id.*, at 158. The terms of the brochure are incorporated into the agency/carrier contract. *Id.*, at 89. The carrier distributes the brochure with a seal attached to the front stating, "Authorized for distribution by the United States Office of Personnel Management Retirement and Insurance Service." *Id.*, at 155.

The program is largely funded by the Federal Govern-

ment. More specifically, the Federal Government pays about 75% of the plan premiums; the enrollee pays the rest. §8906(b). These premiums are deposited into a special fund in the United States Treasury. §8909(a). The carrier typically withdraws money from the fund to pay for covered health care services, *ibid.*; however, the fund's money belongs, not to the carrier, but to the federal agency that administers the program. After benefits are paid, any surplus in the fund can be used at the agency's discretion to reduce premiums, to increase plan benefits, or to make a refund to the Government and enrollees. §8909(b); 5 CFR §890.503(c)(2) (2005). The carrier is not at risk. Rather, it earns a profit, not from any difference between plan premiums and the cost of benefits, but from a negotiated service charge that the federal agency pays directly.

Federal regulations provide that the federal agency will resolve disputes about an enrolled employee's coverage. §890.105(a)(1); see also 5 U. S. C. §8902(j) (requiring carrier to provide health benefit if OPM concludes that enrollee is entitled to the benefit under the contract). The agency's resolution is judicially reviewable under the Administrative Procedure Act in federal court. 5 CFR §890.107 (2005).

In sum, the statute is federal, the program it creates is federal, the program's beneficiaries are federal employees working throughout the country, the Federal Government pays all relevant costs, and the Federal Government receives all relevant payments. The private carrier's only role in this scheme is to administer the health benefits plan for the federal agency in exchange for a fixed service charge.

B

The plan at issue here, the Blue Cross Blue Shield Service Benefit Plan, is the largest in the statutory pro-

gram. The plan's details are contained in Blue Cross Blue Shield's contract with the federal agency and in the brochure, which binds the enrolled employee to that contract. In this case, the carrier seeks to require the enrolled employee's estate to abide by provisions that permit the carrier to obtain (and require the enrolled employee to pay) reimbursement from an enrollee for benefits provided if the enrollee recovers money from a third party (as compensation for the relevant injury or illness). The parties dispute the proper application of some of those provisions.

First, the agency's contract with the carrier requires the carrier to "mak[e] a reasonable effort to seek recovery of amounts to which it is entitled to recover." App. 95. And the carrier must do so "under a single, nation-wide policy to ensure equitable and consistent treatment for all [enrollees] under this contract." *Ibid.* Any money recovered by the carrier goes into the statutory fund in the United States Treasury, and may be spent for the benefit of the program at the discretion of the federal agency. See *supra*, at 3.

Second, the agency/carrier contract and the brochure set forth the enrollee's obligation to reimburse the carrier under certain circumstances. The contract states, "The Carrier may . . . recover directly from the [enrollee] all amounts received by the [enrollee] by suit, settlement, or otherwise from any third party or its insurer . . . for benefits which have also been paid under this contract." App. 95. The agency/carrier contract also says that the "[c]arrier's subrogation rights, procedures and policies, including recovery rights, shall be in accordance with the provisions of the agreed-upon brochure text." *Id.*, at 100. The relevant provisions in the brochure (which also appear in the appendix to the agency/carrier contract) tell the enrollee:

> "If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if

> we pay benefits for that injury or illness, you must agree to the following:
> "All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. . . .
> "We will not reduce our share of any recovery unless we agree in writing to a reduction, . . . because you had to pay attorneys' fees." *Id.*, at 165.

The enrollee must abide by these requirements because, as explained above, the brochure tells the beneficiary that, by enrolling in the program, he or she is agreeing to the terms of the brochure, which in turn "describes the benefits of the [plan] under [the agency/carrier] contract." *Id.*, at 158.

II

A

I have explained the nature of the program and have set forth the terms of the agency/carrier contract in some detail because, once understood, their federal nature brings this case well within the scope of the relevant federal jurisdictional statute, 28 U. S. C. §1331, which provides jurisdiction for claims "arising under" federal law. For purposes of this statute, a claim arises under federal law if federal law creates the cause of action. *Merrell Dow Pharmaceuticals Inc.* v. *Thompson*, 478 U. S. 804, 808 (1986); see also *American Well Works Co.* v. *Layne & Bowler Co.*, 241 U. S. 257, 260 (1916) (opinion of Holmes, J.) (A "suit arises under the law that creates the cause of action"). And this Court has explained that §1331's "statutory grant of 'jurisdiction will support claims founded upon federal common law as well as those of a statutory origin.'" *National Farmers Union Ins. Cos.* v. *Crow Tribe*, 471 U. S. 845, 850 (1985); see also *Illinois* v. *Milwaukee*, 406 U. S. 91 (1972); C. Wright, A. Miller, & E.

Cooper, Federal Practice and Procedure §4514, p. 455 (2d ed. 1996) ("A case 'arising under' federal common law presents a federal question and as such is within the original subject-matter jurisdiction of the federal courts"). In other words, "[f]ederal common law as articulated in rules that are fashioned by court decisions are 'laws' as that term is used in §1331." *National Farmers*, *supra*, at 850.

It seems clear to me that the petitioner's claim arises under federal common law. The dispute concerns the application of terms in a federal contract. This Court has consistently held that "obligations to and rights of the United States under its contracts are governed exclusively by federal law." *Boyle* v. *United Technologies Corp.*, 487 U. S. 500, 504 (1988). This principle dates back at least as far as *Clearfield Trust*, 318 U. S., at 366, where the Court held that the "rights and duties of the United States on [federal] commercial paper," namely a federal employee's paycheck, "are governed by federal rather than local law." The Court reasoned that "[w]hen the United States disburses its funds or pays its debts, it is exercising a constitutional function or power," a power "in no way dependent on the laws of Pennsylvania or of any other state." *Ibid.* Accordingly, "[i]n [the] absence of an applicable Act of Congress it is for the federal courts to fashion the governing rule of law." *Id.*, at 367.

This Court has applied this principle, the principle embodied in *Clearfield Trust*, to Government contracts of all sorts. See, *e.g.*, *West Virginia* v. *United States*, 479 U. S. 305, 308–309 (1987) (contract regarding federal disaster relief efforts); *United States* v. *Kimbell Foods, Inc.*, 440 U. S. 715, 726 (1979) (contractual liens arising from federal loan programs); *United States* v. *Little Lake Misere Land Co.*, 412 U. S. 580, 592 (1973) (agreements to acquire land under federal conservation program); *United States* v. *Seckinger*, 397 U. S. 203, 209 (1970) (Government

construction contracts); *United States* v. *County of Allegheny*, 322 U. S. 174, 183 (1944) (Government procurement contracts).

In this case, the words that provide the right to recover are contained in the brochure, which in turn explains the provisions of the contract between the Government and the carrier, provisions that were written by a federal agency acting pursuant to a federal statute that creates a federal benefit program for federal employees. At bottom, then, the petitioner's claim is based on the interpretation of a federal contract, and as such should be governed by federal common law. And because the petitioner's claim is based on federal common law, the federal courts have jurisdiction over it pursuant to §1331. The lower federal courts have similarly found §1331 jurisdiction over suits between private parties based on Federal Government contracts. See, *e.g.*, *Downey* v. *State Farm Fire & Casualty Co.*, 266 F. 3d 675, 680–681 (CA7 2001) (Easterbrook, J.) (National Flood Insurance Program contracts); *Almond* v. *Capital Properties, Inc.*, 212 F. 3d 20, 22–24 (CA1 2000) (Boudin, J.) (Federal Railroad Administration contract); *Price* v. *Pierce*, 823 F. 2d 1114, 1119–1120 (CA7 1987) (Posner, J.) (Dept. of Housing and Urban Development contracts).

B

What might one say to the contrary? First, I may have made too absolute a statement in claiming that disputes arising under federal common law are (for jurisdictional purposes) cases "arising under" federal law. After all, in every Supreme Court case I have cited (except *National Farmers* and *Milwaukee*, and not including the Court of Appeals cases), the United States was a party, and that fact provides an independent basis for jurisdiction. See 28 U. S. C. §§1345, 1346(a)(2), 1491(a)(1). In those cases the decision to apply federal common law was, therefore, a

"choice-of-law issue" only, *ante*, at 10, and the Court consequently did not need to address the application of the *Clearfield Trust* doctrine to §1331 "arising under" jurisdiction.

But I have found no case where a federal court concluded that federal common law governed a plaintiff's contract claim but nevertheless decided that the claim did not arise under federal law. I have found several lower court cases (cited *supra*, at 7) where courts asserted §1331 jurisdiction solely on the basis of federal common law. And in *Machinists* v. *Central Airlines, Inc.*, 372 U. S. 682, 693, n. 17 (1963), this Court cited the *Clearfield Trust* cases in finding §1331 jurisdiction over the contract suit before it, noting that although those cases "did not involve federal jurisdiction as such," nevertheless "they are suggestive" on the issue of §1331 jurisdiction over suits involving Federal Government contracts "since they hold federal law determinative of the merits of the claim."

It is enough here, however, to assume that federal common law means federal jurisdiction where Congress so intends. Cf. *Clearfield Trust*, *supra*, at 367 ("*In absence of an applicable Act of Congress* it is for the federal courts to fashion the governing rule of law according to their own standards" (emphasis added)). If so, there are strong reasons for the federal courts, following *Clearfield Trust*, to assume jurisdiction and apply federal common law to resolve this case.

First, although the nominal plaintiff in this case is the carrier, the real party in interest is the United States. Any funds that the petitioner recovers here it must pay directly to the United States, by depositing those funds in the FEHBA United States Treasury account managed by the federal agency. The carrier simply administers the reimbursement proceeding for the United States, just as it administers the rest of the agency/carrier contract. Accordingly, this case, just like the *Clearfield Trust* cases, concerns the "rights of the United States under its con-

tracts." *Boyle*, 487 U. S., at 504.

Second, the health insurance system FEHBA establishes is a federal program. The Federal Government pays for the benefits, receives the premiums, and resolves disputes over claims for medical services. Given this role, the Federal Government's need for uniform interpretation of the contract is great. Given the spread of Government employees throughout the Nation and the unfairness of treating similar employees differently, the employees' need for uniform interpretation is equally great. That interest in uniformity calls for application of federal common law to disputes about the meaning of the words in the agency/carrier contract and brochure. See *Clearfield Trust*, 318 U. S., at 367 (applying federal common law because the "desirability of a uniform [federal] rule is plain"); see also *Bank of America Nat. Trust & Sav. Assn.* v. *Parnell*, 352 U. S. 29, 33, 34 (1956) ("[L]itigation with respect to Government paper . . . between private parties" may nevertheless "be governed by federal [common] law" where there is "the presence of a federal interest"). And that interest in uniformity also suggests that the doors of the federal courts should be open to decide such disputes.

Third, as discussed above, the provisions at issue here are just a few scattered islands in a sea of federal contractual provisions, all of which federal courts will interpret and apply (when reviewing the federal agency's resolution of disputes regarding benefits). Given this context, why would Congress have wanted the courts to treat those islands any differently? I can find no convincing answer.

Regardless, the majority and the Court of Appeals believe they have come up with one possible indication of a contrary congressional intent. They believe that the statute's jurisdictional provision argues against federal jurisdiction where the United States is not formally a party. That provision gives the federal district courts "original jurisdiction, concurrent with the United States Court of

Federal Claims, of a civil action or claim against the United States founded on this chapter." 5 U. S. C. §8912. According to the majority, if Congress had wanted cases like this one to be brought in the federal courts, it would have extended §8912 to cover them. *Ante*, at 15–16.

That is not so. Congress' failure to write §8912 to include suits between carriers and enrollees over plan provisions may reflect inadvertence. Or it may reflect a belief that §1331 covered such cases regardless. Either way, §8912 tells us nothing about Congress' intent in respect to §1331 jurisdiction.

But why then did Congress write §8912 at all? After all, the cases there covered—contract claims against the Federal Government "founded on" the federal health insurance program—would also be governed by federal common law and (if my view is correct) would have fallen within the scope of §1331. What need would there have been (if my view is correct) to write a special section, §8912, expanding federal jurisdiction to encompass these claims?

The answer, as the majority itself points out, *ante*, at 5, is that Congress did not write §8912 to expand the jurisdiction of the federal courts. It wrote that section to transfer a category of suits (claims against the United States exceeding $10,000) from one federal court (the Court of Federal Claims) to others (the federal district courts).

In sum, given *Clearfield Trust*, *supra*, and its progeny, there is every reason to believe that federal common law governs disputes concerning the agency/carrier contract. And that is so even though "it would have been easy enough for Congress to say" that federal common law should govern these claims. See *ante*, at 15. After all, no such express statement of congressional intent was present in *Clearfield Trust* itself, or in any of the cases relying on *Clearfield Trust* for the authority to apply federal common law to interpret Government contracts. See, *e.g.*, cases cited *supra*, at 6–7; see also *Clearfield Trust*, *supra*,

at 367 ("In absence of an applicable Act of Congress it is for the federal courts to fashion the governing rule of law according to their own standards"). Accordingly, I would apply federal common law to resolve the petitioner's contract claim. And, as explained above, when the "governing rule of law" on which a claim is based is federal common law, then the federal courts have jurisdiction over that claim under §1331.

C

The Court adds that, in spite of the pervasively federal character of this dispute, state law should govern it because the petitioner has not demonstrated a "'significant conflict . . . between an identifiable federal policy or interest and the operation of state law.'" *Ante*, at 12. But as I have explained, see *supra*, at 8–9, the Federal Government has two such interests: (1) the uniform operation of a federal employee health insurance program, and (2) obtaining reimbursement under a uniform set of legal rules. These interests are undermined if the amount a federal employee has to reimburse the FEHBA United States Treasury fund in cases like this one varies from State to State in accordance with state contract law. We have in the past recognized that this sort of interest in uniformity is sufficient to warrant application of federal common law. See, *e.g.*, *Boyle*, 487 U. S., at 508 ("[W]here the federal interest requires a uniform rule, the entire body of state law applicable to the area conflicts and is replaced by federal rules"); *Kimbell Foods*, 440 U. S., at 728 ("Undoubtedly, federal programs that 'by their nature are and must be uniform in character throughout the Nation' necessitate formulation of controlling federal rules"); *Clearfield Trust*, *supra*, at 367 (applying federal common law because "application of state law . . . would subject the rights and duties of the United States to exceptional uncertainty" and "would lead to great diversity in results by making identical transactions subject to the vagaries of

the laws of the several states," and therefore "[t]he desirability of a uniform rule is plain").

But even if the Court is correct that "'[t]he prudent course'" is "'to adopt the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation,'" *ante*, at 11 (quoting *Kimbell Foods*, *supra*, at 740), there would still be federal jurisdiction over this case. That is because, as *Clearfield Trust*, *Kimbell Foods*, and other cases make clear, the decision to apply state law "as the *federal rule of decision*" is *itself* a matter of federal common law. See, *e.g.*, *Kimbell Foods*, *supra*, at 728, n. 21 ("'Whether state law is to be incorporated *as a matter of federal common law* . . . involves the . . . problem of the relationship of a particular issue to a going federal program'" (emphasis added)); *Clearfield Trust*, *supra*, at 367 ("In our choice of the *applicable federal rule* we have occasionally selected state law" (emphasis added)); see also R. Fallon, D. Meltzer, & D. Shapiro, Hart and Wechsler's The Federal Courts and the Federal System 700 (5th ed. 2003) ("[T]he current approach, as reflected in [*Kimbell Foods*, *supra*], suggests that . . . while under *Clearfield* federal common law governs, in general it will incorporate state law as the rule of decision"); C. Wright, A. Miller, & E. Cooper, Federal Practice and Procedure §4518, at 572–573 ("In recent years, the Supreme Court has put increasing emphasis on the notion that *when determining what should be the content of federal common law, the law of the forum state should be adopted absent some good reason to displace it*" (emphasis added; citing *Kimbell Foods*, *supra*, and *Clearfield Trust*, *supra*)).

On this view, the *Clearfield Trust* inquiry involves two questions: (1) whether federal common law governs the plaintiff's claim; (2) if so, whether, *as a matter of federal common law*, the Court should adopt state law as the proper "'*federal* rule of decision,'" *ante*, at 11 (emphasis added). See, *e.g.*, *Kimbell Foods*, *supra*, at 727 (deciding

that "[f]ederal law therefore controls" the dispute but concluding that state law gives "content to this federal rule"); *United States* v. *Little Lake Misere Land Co.*, 412 U. S., at 593–594 (The "first step of the *Clearfield* analysis" is to decide whether "'the courts of the United States may formulate a rule of decision,'" and the "next step in our analysis is to determine whether" the federal rule of decision should "'borro[w]' state law"); see also Friendly, In Praise of *Erie*—and of the New Federal Common Law, 39 N. Y. U. L. Rev. 383, 410 (1964) ("*Clearfield* decided not one issue but two. The first . . . is that the right of the United States to recover for conversion of a Government check is a federal right, so that the courts of the United States may formulate a rule of decision. The second . . . is whether, having this opportunity, the federal courts should adopt a uniform nation-wide rule or should follow state law" (footnote omitted)). Therefore, even if the Court is correct that state law applies to claims involving the interpretation of some provisions of this contract, the decision whether and when to apply state law should be made by the federal courts under federal common law. Accordingly, for jurisdictional purposes those claims must still arise under federal law, for federal common law determines the rule of decision.

Finally, the footnote in *Boyle* cited by the Court did not purport to overrule *Clearfield Trust* on this point. See *Boyle*, *supra*, at 507, n. 3 ("If the distinction between displacement of state law and displacement of federal law's incorporation of state law ever makes a practical difference, it at least does not do so in the present case").

With respect, I dissent.